IV. Priorities, Performance and Program Activities

A. Background and Overview

The Family and Community Health Bureau (FCHB) has served as Montana's Title V agency for over 20 years. In that capacity, the FCHB has continually monitored, assessed, provided, and advocated, to the extent possible, for the health and well being of the state's women of child bearing age, pregnant women, infants, children and children and youth with special health care needs. The Title V Maternal Child Health Block Grant provides a much needed funding source for addressing the MCH population's unique and oftentimes challenging health needs. In spite of the challenges, an average of 97,007 women, infants, children and children with special health care needs received services supported by the MCH Block Grant.

Montana's 2010 MCH Needs Assessment is a compilation of information, reflecting the work of FCHB programs, and public and private partner organizations. The 2010 MCH Needs Assessment also included input from consumers, which included teens, parents of children with special health care needs, and parents of children and infants ages 0 to 12 years; Montana's Lead Local Public Health Officials; health care professionals; members of the Public Health System Improvement (PHSI) Task Force; and representatives from county health departments that are contracted to provide MCH services in their communities.

There was a consensus from the PHSI Task Force and others working on the SPM selection that Montana must focus on improving Montana's childhood immunization rate; Montana presently has the worst IZ rate for the 19-35 age group in the country. Because of the magnitude of concern, two SPMs were selected to complement the existing NPM 7. SPM #6 focuses on children 19-35 months of age who have received all age-appropriate immunizations against Diphtheria, Tetanus, and Pertussis and SPM #7 specifically addresses compliance with the state's requirement of a Varicella immunization for children 19 to 35 months of age. The other five state performance measures address access to care; oral health for children; preconception health; child safety and unintentional injury; and smoking during pregnancy.

Through the years, the FCHB has increased its partnerships and collaborations with other state agencies and private entities for the purposes of providing program activities aimed at any one of the four service levels found in the MCH Pyramid: direct health care, enabling, population-based, and infrastructure building. The new SPMs offer numerous opportunities for developing new partnerships, as well as strengthening the current partnerships, with the goal of maximizing and leveraging when possible, state and federal dollars for the purposes of improving the health of all Montanans, especially the MCH target population.

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As illustrated in the Agency Capacity attachment, additional partners have been added to the FCHB list of private and public entities addressing any of the services outlined on the Title V pyramid. The Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program grant opportunity has strengthened several established partnerships as well as expanded to new partnerships.

The state's immunization rate continues to be of concern which resulted in the 2012 MCH Block Grant contract being modified. This verbiage, "If NPM 7 or SPM 6 or SPM 7 are selected, the contractor will complete the requirements as outlined on their Immunization Task Order" was included in each contract with the goal of stressing to the health departments the partnership between the FCHB and Communicable Disease Control and Prevention Bureau, which houses the Immunization Program. As stated in the State Priorities section, Montana's immunization rate remains a priority on the Public Health and Safety Division Strategic Plan.
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B. State Priorities

The Family and Community Health Bureau (FCHB) solicited input on the needs of the MCH population, resources and gaps, and capacity through surveys of local partners and programs providing MCH-related services, focus groups, and key informant interviews. In the fall of 2009, 34 topics were initially identified as possible priority areas for the MCH population. These topic areas included exposure to secondhand smoke in childhood, adolescent tobacco, alcohol and drug use, women's mental health and safe home environment. A more detailed list of the thirty four suggested priority areas is included in the 2010 MCH Needs Assessment document.

Subsequent meetings of the FCHB Needs Assessment Planning Team produced a more reasonable list of priority areas. The initial methodology for selecting the priority areas included:

- Relevant to one of the three MCH populations
- Stakeholder/public input indicates an interest or need
- Data available on the topic
- Data supports need
- Capacity to address topic
- Political will/interests
- Not already measured by a National Performance Measure
- Within the responsibility of the MCH or CYSHCN Director
- System in place to address the need
- Topic or issue can be sufficiently focused
- Possible interventions or approaches to address priority area can be identified

After the FCHB Needs Assessment Planning Team narrowed down the list using the criteria, discussions took place with the Public Health System Improvement (PHSI) Task Force. The PHSI Task Force includes representatives from local health departments (one each from large, medium, small, and frontier-sized counties), and representatives from a variety of agencies or associations throughout the state, including the Montana University System, tribal health departments, local boards of health, the Montana Primary Care Association, and the Billings Area Indian Health Service.

The stated purpose of the PHSI Task Force is to:

- Assess Montana's progress in implementing the goals and objectives of the Strategic Plan for Public Health System Improvement and other system improvement efforts.
- Ensure the implementation of the Strategic Plan with updated "action plans."
- Provide policy development recommendations to state and local agencies regarding public health system improvement issues.
- Advocate for statewide public health system improvement efforts.

Source: (PHSITF Charter retrieved 6/7/2010 at http://www.dphhs.mt.gov/PHSD/phsi/pdf/2009-PHSI-TaskForceCharter.pdf)

The PHSI Task Force was responsible for the final identification of the MCH priority areas and state performance measures based on the availability of data on a measure to indicate a baseline or progress toward a goal, the political and financial support/resources to address the priority area, and most importantly, the capacity for addressing the priority area at a state or local level. Furthermore, the PHSI Task Force recommended that the MCH priority areas and new state performance measures have an identified measure that was relevant at either the state or local level.

The following are Montana's priority areas for its MCH population for 2010 - 2015:

- Child safety/unintentional injury

- Access to care
- Preconception health
- Smoking during pregnancy
- Oral Health
- Montana's rate for the required Varicella immunization
- Montana's rate for the required Diphtheria, Tetanus, and Pertussis immunization series

The FCHB is one of five bureaus in the Public Health and Safety Division (PHSD), which has created its own 2007-2012 Strategic Plan to addresses its mission: To improve the health of Montanans to the highest possible level. The PHSD Strategic Plan (attached document) includes several Health Improvement Priorities that target the MCH population and can be tied to a national performance measure (NPM) or state performance measure (SPM), as illustrated:

PHSD Strategic Plan Health Improvement Priority Area and Related NPM and SPMs

Maintain programs that provide services to women (pre-pregnancy, prenatal, and post-natal) and children.
NPM #1, #2, #3, #4, #5, #6, #8, #9, #11, #12, #13, #14, #17, #18
SPM #1, SPM #2, SPM #3

Reduce unintentional injuries and deaths among Montanans from motor vehicle accidents, falls, poisoning, and other preventable injury-related deaths.
NPM #10, NPM #16
SPM #4

Increase the number of tobacco-free Montanans.
NPM #15
SPM #5

Increase childhood immunization rates for Diphtheria, Tetanus, Pertussis, Varicella and other vaccine
preventable conditions.
NPM #7
SPM #6, SPM #7

The selection of state needs and priority areas is an ongoing process requiring assessment of health
status and system functioning indicators as well as the availability of financial and human resources. The fiscal impact of MCH Block Grant funding remaining at the same level for the past several years has been felt in Montana. As mentioned elsewhere in this application, approximately 42% of the state's MCH Block Grant allocation is distributed to 54 of the state's 56 local health departments. Lack of an increase in the MCH Block Grant does not provide for the ongoing increase in the cost of providing services at the local level. Thus, Montana's total number served continues to decrease.

Fiscal and human resource challenges affect every state, but are perhaps more distinct or apparent where the rural/frontier nature and sparse distribution of clients and providers place multiple demands upon a very fragile public health infrastructure. As the FCHB moves forward with the new priority areas and state performance measures, the FCHB 2010-2015 MCH Block Grant Strategic Plan is the tool that will be used to monitor, assess, and evaluate that the State Title V Agency and the FCHB continue to have the capacity and resource capability for addressing the national and state performance measures.

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As stated elsewhere in this document, despite the MCH BG funding being decreased,

vacancy savings and travel restrictions, have contributed to maintaining approximately 41% to 42% of the funding being allocated to the local health departments for addressing the one National or State Performance Measure for their community. Any monetary changes to a local health department's 2012 funding is the result of their county's 2009 population for women of child-bearing age, children ages 0 to 18, and the number of living in poverty.

The Public Health System Improvement (PHSI) Task Force will continue to provide input to the state priorities, which remain unchanged, and to the State Performance Measures.

As stated elsewhere, the state's immunization rate continues to be of concern and as such is a Health Improvement Priority on the Public Health and Safety Division's (PHSD) Strategic Plan which is attached. Immunization also appears to be a priority area for the local health departments. For SY 2012, 35 of the 53 county health departments opting to receive 2012 funding selected an immunization performance measure: 30 selected NPM 7; 4 selected SPM 6, and 1 selected SPM 7. Additionally, the Bureau Chief is invited to participate on the PHSD telephone conference calls with the Lead Local Health Officials, which when appropriate may include discussion about the PHSD's priority areas.

//2012//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	7	9	17	15	12
Denominator	7	9	17	15	12
Data Source			MT newborn screening and follow-up program	MT newborn screening and follow-up program	MT newborn screening and follow-up program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**

Annual Performance Objective	100	100	100	100	100

Notes - 2010
Fewer cases were confirmed and received timely follow-up compared to the previous year based on the mandatory hospital-based screening of newborns for 28 genetic conditions.

Notes - 2009
Fewer cases were confirmed and received timely follow-up compared to the previous year based on the mandatory hospital-based screening of newborns for 28 genetic conditions.

Notes - 2008
2008 was the first year Montana had mandatory hospital-based screening of newborns for 28 genetic conditions. This performance measures includes the results and follow-up for those tests. The increase in the number of conditions is due to the increase in the number and types of tests conducted.

a. Last Year's Accomplishments
The Montana Newborn Metabolic Screening (MT NBS) program is a partnership between Children's Special Health Services (CSHS), the Montana Public Health Laboratory (MT-PHL), and the infant's medical home provider. The overall goal of the Montana Newborn Metabolic Screening Program is that every newborn with an initial abnormal or screen positive result is tracked by the NBS program coordinator to a normal result or appropriate clinical care.

The MT-PHL received all Montana bloodspot specimens and screened for phenylketonuria, galactosemia, congenital hypothyroidism, hemoglobinopathies, and cystic fibrosis. Specimens were then shipped to the Wisconsin State Laboratory of Hygiene (WSLH) for completion of the screening panel. Approximately 4% of babies needed a program-mandated repeat screen due to unsatisfactory specimens or out of range test results on the initial newborn screen. The NBS coordinator was responsible for short term follow-up to ensure that repeat screening occurred, and facilitated secure information sharing of positive screening results with the long term follow-up contractor via CHRIS software. The coordinator manually matched screening records to birth certificates and identified babies who had missed screening within weeks of birth. In several cases, this matching revealed loss of newborn screening specimens during transport to the MT-PHL.

A high percentage of Montana's newborns (98.7%) received at least one bloodspot screen in 2010 that included the American College of Medical Genetics recommended panel. Of the 11954 infants (11915 with a Montana birth certificate) who received at least one Montana newborn screen in 2010, 29 were screen positive for one of the 28 mandated conditions. Of these, 12 were diagnosed with a condition and are being treated. An additional 17 infants were presumed carriers of abnormal hemoglobin traits and referred for follow-up genetic services. Infants with diagnosed conditions in 2010 included two with congenital hypothyroidism, one with sickle cell anemia, two with a disorder of fatty acid metabolism, one with organic acidemia, and six with cystic fibrosis.

In June 2009, the NBS coordinator position was re-defined under the supervision of the MT-PHL. The coordinator relayed abnormal results directly to providers to give them more complete, consistent, and clinically relevant information. The coordinator prepared an "Unsatisfactory Specimen" policy in December 2009 for the MT-PHL. Standards consistent with Wisconsin's are now applied to Montana specimens. In December 2009, the MT-PHL called more than 7% of NBS specimens unsatisfactory. The coordinator provided submitters with intensive education and reinforcement by phone and email. Unsatisfactory specimens dropped to 1.3% by April 2010 and continued at this level.

As of June 2010, the follow-up contractor employed a board-certified biochemical geneticist who

resides in Montana. MT NBS partners (CSHS, laboratory, follow-up contractor) met every other month and reviewed program statistics (% infants screened, initial positives, screen positives, confirmed diagnosis, treatment), accomplishments, and challenges for calendar year 2010 in order to improve sustainability and accountability for the program. This group reached consensus on a change in reporting protocol for unknown hemoglobin variant traits which was then adopted by the MT-PHL. A fact sheet on unknown hemoglobin variants was developed and is now faxed to providers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify babies with Montana birth certificates who have no newborn screening data within eight weeks of their birth and determine reason for no screening.		X		
2. Ensure that all newborns with confirmed conditions are referred to the contractor for long-term follow-up and relay results to the primary care provider in the medical home.		X		
3. Ensure partners and decision makers review program statistics, accomplishments, and challenges to improve sustainability and accountability for the program.				X
4. Apply a consistent standard for unsatisfactory specimens with Wisconsin and educate submitters to reduce the unsatisfactory percentage.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Screening for Severe Combined Immunodeficiency (SCID) was added to the recommended newborn screening (NBS) panel in 2010. MT NBS Program personnel viewed a national webinar on SCID results from Wisconsin, California, Massachusetts, and New York in May 2011.

Montana will monitor standardization of algorithms for screening, confirmatory testing and referral for transplant. As of June 2010, the follow-up contractor employs a board-certified biochemical geneticist who resides in Montana, staffs the regional metabolic clinics, and provides expert consultation to primary providers.

In December 2010, MT PHL implemented a more comprehensive referral protocol for reporting out of range results. The NBS coordinator tracks most infants with abnormal results to a normal repeat screen. Those infants with presumptive positive results are referred immediately to the contractor for documentation in CHRIS of confirmatory testing, definitive diagnosis, and clinical management.

In January 2011, program partners and cystic fibrosis (CF) specialists reviewed program data and updated the age-dependent ranges for Montana's IRT/ IRT screening algorithm (implemented March 2011). Additions to the website this year include information about CF screening, unknown hemoglobin variants, and privacy policies.
As of November 2010, NBS reports include birth weight and other demographic information, distinctly flag out-of-range results, and have clear recommendations for the provider.

c. Plan for the Coming Year

As SCID screening is standardized and adopted by more state programs, the MT NBS program will consult with experts, providers, and other interested parties regarding addition of SCID to Montana's mandated panel. The screening test would be performed at a regional center, presumably Wisconsin. The health department will need to determine what resources for screening, treatment, and counseling are available. Additions to the mandated panel are made by health department regulations, Administrative Rules. Legislation is not required for additions to Montana's bloodspot screening panel.

MT NBS partners and CF specialists will review data after the updated IRT/ IRT screening algorithm has been in place for approximately twelve months. CF specialist cooperation with the CSHS-supported regional clinics should facilitate documentation of confirmatory testing, definitive diagnosis, and clinical management.

MT NBS partners and Montana's providers of neonatal intensive care will work together to streamline screening for premature and sick infants, based on finalized national guidelines from the Clinical and Laboratory Standards Institute. More than 40% of Montana infants with initial out-of-range screening results are receiving intensive care. The goal is to complete NBS for every sick/ premature infant in the shortest period of time, with the highest degree of reliability and using the fewest number of specimens. Neonatal providers have requested clearer Administrative Rules from the health department after a consensus is reached on the optimal protocol.

A new laboratory supervisor for newborn screening began at MT-PHL in March 2011. The NBS coordinator works with her to improve program quality. The NBS coordinator will complete deferred projects such as submission of additional anonymized specimens to a regional CDC-funded project evaluating 2nd tier testing for congenital adrenal hyperplasia and other conditions. The NBS coordinator will also take part in a deferred quality improvement project to evaluate specimen transport processes and track specimen transport times to ensure timely delivery of specimens to MT PHL. A LEAN analysis of data handling in the program was initiated in 2010. When the analysis is complete, the health department will determine whether available resources will support addition of customized software for tracking and documenting screening completion, linking birth and screening records, and managing and reporting interoperable NBS data. Expansion of the NBS program website will continue as part of a department-wide upgrade to include additional information for providers and families.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**12070**					
Reporting Year:	**2010**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	11915	98.7	0	0	0	
Congenital Hypothyroidism	11915	98.7	2	2	2	100.0

(Classical)						
Galactosemia (Classical)	11915	98.7	0	0	0	
Sickle Cell Disease	11915	98.7	1	1	1	100.0
Biotinidase Deficiency	11915	98.7	2	0	0	
Congenital Adrenal Hyperplasia	11915	98.7	4	0	0	
Cystic Fibrosis	11915	98.7	7	6	6	100.0
Maple Syrup Urine Disease	11915	98.7	1	0	0	
Tyrosinemia Type I	11915	98.7	2	0	0	
Hemoglobinopathy	11915	98.7	18	1	1	100.0
Acylcarnitine profile for (5) fatty acid oxidation disorders (CUD,MCAD,LCHAD,VLCAD,TFP)	11915	98.7	8	2	2	100.0
Acylcarnitine profile for (9) organic aciduria disorders (HMG,3MCC,BKT,GA1,IVA,CblAB,MUT,MCD,PROP)	11915	98.7	2	1	1	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	55.3	55.6	56.5	56.5	56.5
Annual Indicator	54.0	56.5	56.5	56.5	56.5
Numerator	188				
Denominator	348				
Data Source			CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	56.5	56.5	56.5	56.5	

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
According to the National Survey of Children with Special Health Care Needs (NS-CSHCN), the percent of families that had children with special health care needs ages zero to 18 years in MT

who partnered in decision making at all levels and were satisfied with the services they received was 56.5 percent in 2005/2006. This is lower than the national percentage of 57.4 in 2005/2006.

Shodair, the contractor for the genetics and newborn screening follow-up contractor, conducted patient satisfaction surveys. See attachment. In 2010the survey instrument was sent to 734 families and 110 families returned the survey. The overall family satisfaction score from 2010 clinics was 4.9 (scale of 1-5 with 5 being the highest).

Shodair conducted its 2nd annual Metabolic Day in August of 2010. The event hosted families, provided information about living with metabolic conditions, and offered support and networking opportunities. Families were given a survey on metabolic and genetics clinics which asked for input on a variety of topics, including the extent to which the family's feelings were valued and respected, interaction with the child and whether families received the information they needed.

Shodair created binders for the metabolic patients attending Children's Special Health Services (CSHS) interdisciplinary metabolic clinics. These binders had gender specific materials and space for all clinic related materials so the patient and family could retain and organize the information.
CSHS assessed the need for the families of children and youth with special health care needs (CYSHCN) to purchase additional health care coverage. CSHS data shows 99% had health care coverage in FFY 2010 (44 had private insurance, 16 had Medicaid and 1 was self-pay). Also, because of the recent Medicaid and Children's Health Insurance Program expansions, families have been able to benefit from coverage from Department of Public Health public assistance programs.

CSHS successfully added additional staffing requirements in the 3 regional pediatric specialty clinic sites. The nurse to visit ratios continued to be high at 1:635.

CSHS attended the Family Day at the School for the Deaf and the Blind and presented information on the CSHS program and partners, as well as networked with families about needs and ability to access care in MT. CSHS received several ideas and suggestions for activities that would benefit CYSHCN. These ideas ranged from parent resource libraries to creating on-going means to solicit feedback about accessing services in MT. CSHS did not implement any of these suggestions due to lack of staff and resources to assess the need and ability to implement.

CSHS and the CSHS Advisory Committee welcomed a new parent representative, who attended her first Advisory Committee meeting in June of 2010. She also attended monthly CSHS staff meetings, provided input on the section activity plan, and met periodically with the CSHS manager. Two other parent representatives continued to serve on the Advisory Committee.

Two of the regional staff, who served on the Advisory Committee, have children with special health care needs. Each member continually shared valuable feedback with CSHS to ensure the program and its services incorporated feedback from CYSHCN and their families. The CSHS Medical Advisor continued to provide technical assistance and guidance to the group as needed.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued active parent participation in CSHS Advisory Subcommittee and other section activities.				X
2. Ongoing collection and analysis of the client satisfaction survey from the Regional Pediatric Specialty clinics.				X
3. Parent participation and input on the CSHS activity plan.				X
4. CSHS Medical Director to continued to provide technical assistance and guidance.				X

5. CSHS assessed the need for the families of CYSHCN to purchase additional health care coverage		X		
6. Added additional staffing requirements in the 3 regional pediatric specialty clinic sites				X
7.				
8.				
9.				
10.				

b. Current Activities

CSHS continues to assess client satisfaction at interdisciplinary clinics and programmatic changes are frequently based on this feedback. Coordinators at the Great Falls Clinic conducted a patient survey in the fall of 2010 to collect information on such things as travel distance. (See attachment) CSHS is working with a parent representative to develop a survey about CSHS Cystic Fibrosis (CF) clinics to evaluate family feedback on the availability and level of services offered at clinics. There will also be a follow-up assessment on the Newborn Screening Follow-up Program and Metabolic Clinic. Shodair, the contractor for the genetics program in MT, will survey each family about clinic interaction.

CSHS was able to coordinate funding to send a parent representative to the 2011 Early Hearing Detection and Intervention (EHDI) conference. She was invited to attend an Advisory Committee meeting to share feedback.

The Rural Institute, Montana's Center of Excellence in Disabilities, conducted surveys after 2 webinar trainings ("Social Security Work Incentives" and "Dating and Healthy Relationships") funded in part by CSHS Of survey participants, 92% rated the webinars they were satisfied or very satisfied, and 80% reported the content of the webinars would be helpful in their lives. (See attachment)

CSHS is offering a stipend to a parent to review the MCH Block Grant Application and offer feedback on any areas that are of interest to families of CYSHCN.
An attachment is included in this section. IVC_NPM02_Current Activities

c. Plan for the Coming Year

CSHS will continue to invite parent representatives to the bi-annual CSHS Advisory Committee meetings to provide input on Committee decisions. A parent representative will also take part in periodic CSHS staff meetings and offer a parent's perspective on program activities and materials developed for distribution by the program.

CSHS plans to provide funding for a parent representative, whose child has been diagnosed with hearing loss, to attend the 2012 National Early Hearing Detection and Intervention Conference as part of the state EHDI Team. The team will also include, the Universal Newborn Hearing Screening and Intervention (UNHSI) Coordinator, an outreach consulting audiologist from the Montana School for the Deaf and the Blind, a pediatrician designated as the Hearing Champion from the Montana chapter of the American Association of Pediatrics, and a hospital employee from one of the birthing facilities, which provides newborn hearing screening services in Montana . CSHS will ask the parent representative to share feedback about the conference and UNHSI program activities to program staff and stakeholders in an effort to ensure that the UNHSI program is meeting the needs of Montana families.

CSHS plans to restructure the Universal Newborn Hearing Screening and Intervention Stakeholders' group, which will include one or more parent representatives. This group will provide input on program activities and help guide future activities and programmatic decisions.

CSHS will continue to require CSHS contractors to conduct client satisfaction surveys and

monitor survey results. Results will be analyzed by CSHS in an effort to identify areas of contracted services in need of improvement to better meet the needs of CYSHCN families.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	52.6	52.6	50	50	50
Annual Indicator	51.7	45.9	45.9	45.9	45.9
Numerator	361				
Denominator	698				
Data Source			CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	50	50	50	50	

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
According to the 2005/2006 National Survey of Children with Special Health Care Needs (NS-CSHCN), the percentage of CYSHCN in MT who received coordinated, ongoing, comprehensive care within a Medical Home was 45.9 percent, which is slightly lower than the national percentage of 47.1 percent.

In FFY 2010, 61% of CSHS program clients reported having an active primary care provider (PCP). Providing referrals for PCP and collecting this information is a standard Children's Special Health Services (CSHS) interdisciplinary clinic activity. Providers of records received copies of specialty clinic visits to facilitate continuity of care.

CSHS continued to maintain its website with listings of pediatric specialty clinics and contact information for scheduling. During the annual Montana American Academy of Pediatrics (MT AAP) meeting, a discussion with PCPs was led by the CSHS Medical Advisor regarding specialty provider shortages in MT. The Medical Advisor also provided regional updates and led a

discussion of CSHS' role in contracting and supporting specialty providers.

CSHS participated in the National Academy for State Health Policy (NASHP) technical assistance grant project for medical homes. There were two stakeholder meetings where participation included the Children's Mental Health Bureau, hospital administrators, health care providers, health insurance company medical directors, county health representatives and two MT Legislators. The stakeholder group has received expert advice regarding establishing a multi-payer medical home concept for the entire state, how to fund such an effort, and technical assistance on how to facilitate these discussions.

CSHS continued to participate in the MT AAP to address topics such as reimbursement rates, medical homes, and care coordination and transportation issues.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. All regional pediatric specialty clinic participants are tracked and referred to medical home as needed.			X	
2. CSHS continues to maintain its website with listings of pediatric specialty clinics and contact information for scheduling.				X
3. CSHS continued to strengthen relationships between the pediatric specialty clinics and primary care providers.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHS is completing year 3 of the Child Health Referral & Information System (CHRIS) web application development. Much of the work completed during this development phase is case management functionality to assist with coordination of care for children and youth with special health care needs (CYSHCN). Functionality now in development will allow a child's primary care provider to view clinic schedules with specialty provider information and to make electronic client referrals for clinic evaluations.

CSHS has developed a Cystic Fibrosis Care Plan which can be accessed by regional nurse coordinators. The care plan is reviewed with the child and family prior to leaving cystic fibrosis (CF) clinic and a copy of the plan is faxed to the child's primary care provider following clinic.

CSHS has continued participation in the MT medical home project. The group has weekly conference calls which often invite guest speakers to share expertise about payment reform and project implementation.

CSHS continues to participate in Medical Home Stakeholder meetings. In the coming year, the stakeholder group will adopt criteria to certify practices as Medical Homes. Also, CSHS will continue to be involved in planning a medical home initiative to include a certification process for practices that choose to participate.

CSHS is contracting with a nurse to assess the different CYSHCN referral sources and develop a referral program that will coordinate referrals to county health departments.
An attachment is included in this section. IVC_NPM03_Current Activities

c. Plan for the Coming Year
CSHS will continue development of the CHRIS web application as funding allows. Funding for development is from several sources. The primary development for the coming year will focus on CSHS clinic scheduling /management functionality and expanded tracking, reporting, and referral management for the Universal Newborn Heading Screening Intervention (UNHSI) Program Also, the functionality allowing primary care providers to access clinic schedules is still considered a priority development effort and is scheduled for completion during the coming year.

To facilitate coordination of care for clients attending cystic fibrosis clinic, CSHS will migrate care plan functionality to the web application. This will make care plans more accessible to regional pediatric specialty clinic staff and will allow CSHS to more easily collect data that is important for monitoring client outcomes over time. Other care plans will be developed as funding allows.

CSHS will continue to participate in Medical Home Stakeholder meetings. In the coming year, the stakeholder group will continue to work towards certifying practices as Medical Homes and possibly develop a self-assessment tool. The stakeholder group will continue gathering data about primary care providers in MT and assess medical home pilot projects that have occurred in MT. The group plans to assess and vote on the level of National Committee for Quality Assurance (NCQA) standards to be applied in MT.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	50.4	50.5	55.2	55.2	55.2
Annual Indicator	48.8	55.2	55.2	55.2	55.2
Numerator	350				
Denominator	717				
Data Source			CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	55.2	57	58.5	58.5	

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
CSHS continued to encourage and support sustainability of follow-up services for children and youth with Special Health Care Needs (CYSHCN) by acting as a resource for clients, primary care and other providers, parents, local health departments, and payer sources.

By raising awareness and understanding of the needs of this population and their families, CSHS builds critical links for ongoing care. CSHS continued billing for Cleft/craniofacial, Cystic Fibrosis, and Metabolic Clinics. This funding is used to support the regional pediatric specialty clinic (RPSC) sites. Newborn Screening (NBS) follow-up program continues to be supported by special revenue. Effective December of 2009, CSHS began sponsoring cystic fibrosis (CF) inter-disciplinary clinics and the revenue achieved is used to sustain CSHS inter-disciplinary clinics. Healthy Montana Kids (HMK) and Healthy Montana Kids Plus (HMKP) continue to support the CSHS clinics.
During FFY 2010, CSHS billed a total of $532,400.00 for CSHS sponsored team clinics and was reimbursed $359,040.91 for 67% of billed charges. Cleft clinic charges were reimbursed at 74%; Metabolic clinic charges were reimbursed at 58%; and Cystic Fibrosis charges were reimbursed at 63%.

For FFY 2010, 61 clients were eligible for up to $2,000 of financial assistance from CSHS. Of the 61, 1 did not have health care coverage; 16 had HMK; 11 had HMKP; and the remaining clients enrolled had some type of health coverage. CSHS enrollment continues to decline due to the changes made in HMK & HMKP. Both programs have raised their poverty guidelines for eligibility.

Effective February 2010, CSHS began receiving SSDI summaries of findings. The physician-drafted forms assess the status of a child's disability.

In December 2009 a 2% rate increase was implemented for targeted case management (TCM) programs for high risk pregnant women & CYSHCN.

CSHS worked with HMK to establish electronic referrals where applicants indicated their child has special health care needs. These applicants are reviewed and receive information about RPSC and CSHS financial assistance.

CSHS continued to work with health care coverage agencies to promote coverage for services needed for CYSHCN. This activity included negotiating rates for CSHS clinics, assisting families with claim appeals, and communicating with health care coverage agencies regarding the necessity of coverage for services and supplies.

CSHS continued to communicate the gaps if coverage to all health care coverage agencies, including when they are a third party payer.

CSHS continues to work with Indian Health Services prior to conducting reservation specialty clinics to ensure that families have a health payer source.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue providing for limited financial assistance for medical services.	X			
2. Continued partnership with Medicaid program regarding		X		

pediatric specialty services in Montana.				
3. Ongoing shared referrals with Health MT Kids (HMK is CHIP).		X		
4. Communication with providers to accept negotiated rate.		X		
5. Provide information to HMK and other insurance regarding coverage needs of CSHCN.				X
6. Continue providing information to health care providers regarding the HMK expansion.		X		
7.				
8.				
9.				
10.				

b. Current Activities

CSHS continues to monitor the health coverage status of all CYSCHN referred to or receiving services from CSHS. Individual health coverage is tracked in the CSHS database, Child Health Referral and Information System (CHRIS). CHRIS is a shared application used by multiple CYSCHN service providers, not all of whom collect health coverage information on clients. Better reporting of health coverage data is a quality assurance issue now being addressed for CSHS.

Two Regional Pediatric Specialty Clinic sites are now staffed by half-time social workers who work with families to obtain health coverage and other assistance. This follow-up has been a long term goal for CSHS and has already had a positive impact for families.

CSHS continues to support the program expansions of Medicaid (HMKP) and CHIP (HMK). A CSHS staff member will attend an extensive Medicaid eligibility training session in July.

For FFY 2011 to date, 54 CSHS clients have been eligible for up to $2,000 in financial assistance using block grant funding. Of the 54 clients, 1 did not have health care coverage. To date, CSHS has $26,251.16, with a cost per child averaging $486.13. All applicants who apply for financial assistance are assessed for HMK or HMKP eligibility. There have been a growing number of requests for Medicaid clients needing genetic testing from out-of-state labs. CSHS is assessing the option of using program funds to cover these services.

c. Plan for the Coming Year

CSHS plans to pursue team billing of insurance companies that are currently not reimbursing CSHS for Cystic Fibrosis clinics.

CSHS plans to implement quality assurance measures to improve the collection of health coverage information in the Child Health Referral and Information (CHRIS) data system. CSHS CHRIS program data represents a snapshot of the CYSCHN population in Montana, and is very useful for understanding the coverage issues that CYSCHN may be experiencing. For example, CSHS is currently reviewing payment information for cochlear implants and health coverage information is under-reported for this population.

Adding a half-time social worker to the 3rd regional pediatric specialty clinic site is under discussion. Helping families to access health coverage can be a time consuming process. Knowledgeable, on-site assistance as well as follow-up between clinic visits will help families navigate the health care system.

CSHS will continue to work with partners, specifically Healthy Montana Kids (HMK) and Healthy Montana Kids Plus (HMKP) to address services not covered by these entities. HMK does not cover durable medical equipment like nebulizers for children with asthma, oxygen necessities, or CPAP's for children with sleep apnea. To cover these items generally means fewer emergency room visits. CSHS staff will receive training about HMKP eligibility to further enable CSHS staff to

accumulate knowledge of the many programs under the HMKP umbrella and be able to guide families as needed.

CSHS will continue offering financial assistance for non-covered or non-accessible services for CYSHCN with public and private health care coverage as well as offer assistance to achieve health care coverage for CYSHCN without adequate coverage. CSHS will continue advocating for non-covered durable medical equipment coverage through the HMK Program as well as for coverage for out of state genetic testing for the Medicaid population.
CSHS will continue referring families to patient assistance programs as needed.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	72.6	72.8	88.6	88.6	88.6
Annual Indicator	71.6	88.6	88.6	88.6	88.6
Numerator	250				
Denominator	349				
Data Source			CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	88.6	90	90	90	

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
According to the 2005/2006 National Survey of Children with Special Health Care Needs (NS-CSHCN), 88.6 percent of MT respondents thought that community-based service systems were "usually" or "always" organized so they could easily use them, compared to 89.1 percent nationally.

CSHS continues to promote increased access to specialty care for CYSHCN at the Regional

Pediatric Specialty Clinics (RPSC) through contracted services and consultation. The RPSC demonstrated continued growth during FFY 2010 with 3803 clinic visits. This represents a 17% increase in clinic visits from FFY 2009. Staffing is adequate at the sites, but with continued growth, the clinic follow-up can be challenging for current staff levels.

Pediatric Specialty clinic development efforts continued to focus on clinical care for clients with cystic fibrosis during FFY 2010. Standardized documents for nutrition, social worker, and respiratory therapy were developed for and implemented for use at cystic fibrosis (CF) clinics. A care plan to be used for reporting and documentation has been developed and is being is used by regional CF team clinic staff. CF clinic clients/parents leave the clinic with a copy of their care plan which is faxed to their primary care provider (PCP) on the day of clinic. Care plans have decreased nurse coordinator documentation time considerably.

A certified nurse specialist (CNS), arranged for a CF education day in Billings during August 2010.

New pediatric specialty providers in MT last year were a pediatric neurologist, a hospitalist/pediatric pulmonologist, and a metabolic geneticist.

CSHS worked with Healthy MT Kids Plus (HMKP/Medicaid) to provide information about the availability of pediatric services in Montana.

Health Montana Kids Plus (HMKP), Healthy Montana Kids (HMK), and CSHS continued to coordinate services between out of state facilities and Montana providers. CSHS contracted with a nurse who is working with Blue Cross Blue Shield of MT, the Medicaid Health Improvement Program (HIP) and Seattle Children's Hospital, focusing on the children and youth with special health care needs (CYSHCN) that are receiving services outside MT, discharge planning, and linking patients to local health departments.

Shodair provided clinical genetics services in 80 outreach clinics so the 76% of families that reside outside the Helena area could receive some services locally. Individuals with metabolic conditions identified by newborn screening are seen in regional clinics which are staffed by Shodair in cooperation with local resources. Shodair also works with county health departments across Montana to coordinate services for clients in their communities.

CSHS continued contacting payers which are not reimbursing for clinic visits, with the intent to increase payments.

CSHS also continues to support CF inter-disciplinary clinics.

CSHS participated on the board for the Pediatric Epilepsy Tele-health (PET) grant which will provide pediatric follow-up neurological care for children with epilepsy.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CSHS continues to promote increased access to specialty care for CYSHCN at the Regional Pediatric Specialty Clinics (RPSC) through contracted services and consultation.				X
2. RSPC clinic development efforts continued to focus on clinical care for clients with CF. Standardized documents for nutrition, social worker, and respiratory therapy were developed and implemented. Care plans were used for reporting and documentatio				X
3. CSHS plans to continue contacting payers that are not				X

reimbursing clinic visits, with the intent to increase payments.				
4. Rosalie Bush, certified nurse specialist (CNS), arranged for a CF education day in Billings during August 2010.			X	
5. CSHS worked with health care coverage agencies to link families to community resources		X		
6. New pediatric specialty providers in MT last year were a pediatric neurologist, a hospitalist/pediatric pulmonologist, and a metabolic geneticist. All are rendering services to CYSHCN.		X		
7.				
8.				
9.				
10.				

b. Current Activities

Because of the distances families travel for care, access to specialty providers continues to be a focal point of Montana's CYSCHN program, CSHS. The downturn in the economy and the cost of gas adds to the complexity of accessing care in a rural state.

CSHS has a part-time nurse consultant whose responsibilities include coordinating follow-up community services for newborns and children who are admitted to out of state hospitals.

The North Central Region Pediatric Specialty Clinic administration is under re-organization. Expansion of clinic services is on hold until this process is completed. The Western Region Pediatric Specialty clinic has a strong affiliation with Seattle Children's hospital and has added Pediatric Gastrointestinal clinics this year. In addition, Seattle Children's Hospital is providing pediatric surgery back-up for the Community Medical Center in Missoula. The Eastern Region Pediatric Specialty Clinic has stable staff and continues to expand with the addition of pediatric neurology clinics.

CSHS continues to coordinate care and referrals with other programs including CHIP (HMK), Medicaid, and the MT School for the Deaf and the Blind, and the social security Disability Determination Bureau. CSHS continues to partner with county public health offices, health care coverage agencies and other partners to ensure access to community resources where available.

All 3 regional sites and Shodair conduct outreach clinics to promote better health outcomes.

c. Plan for the Coming Year

CSHS plans to contract with and provide consultation to the Regional Pediatric Specialty Clinics (RPSC). The RPSC are crucial partners in the pediatric health care system in Montana. CSHS will seek to stabilize funding for nutrition and social work services at the RPSC with additional funding for the regional sites. In addition to staffing the three CSHS sponsored clinics (Cleft/craniofacial, Cystic Fibrosis, and Metabolic Clinics), the county health departments will continue to be available for follow-up and other RPSC clients.

CSHS will continue to facilitate the transition of adults with cystic fibrosis to adult clinic services.

CSHS plans to continue building the follow-up system for CYSHCN who receive care out of state, have extended stays in Newborn Intensive Care Units, and have high special needs by expanding its linkages with public health home visiting, Part C, Medicaid (including the Medicaid Health Improvement Program), CHIP, private payers, out-of-state hospitals and primary care providers.

CSHS will utilize the FFY 2011 genetic services needs assessment to assess and draft a state genetics plan. The needs assessment and state plan will be a result of interviews with genetics

patients/families and medical providers in Montana. The state genetics plan will have several focus points, including the need to continue outreach services in order to promote access and address transportation issues for families of CYSHCN.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	6	6.5	46.5	46.5	46.5
Annual Indicator	5.4	46.2	46.2	46.2	46.2
Numerator	8				
Denominator	147				
Data Source			CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	46.5	47.5	47.5	47.5	

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
According to the 2005-2006 National Survey of Children with Special Health Care Needs (NS-CSHCN), the percent of Montana youth with special health care needs who received the services necessary to make transitions to adult health care, work, and independence was 46.5, which is higher than the national percentage of 41.2.
Shodair Children's Hospital, a contractor for Montana's genetics program and metabolic specialty clinics, provided transition information to youth ages 14-18. These informational resources addressed education, employment, medical care, and living arrangements.

A CSHS staff member continued to serve on the Montana Transition Information and Resource Center (MT-TIRC) Advisory Board. The Board continued to address issues identified in part by

youth members who make up more than 50% of the membership. Among these issues were healthcare, mental health issues, work, and living arrangements. The Board identified several new ways to provide mentoring to families in the transition process through social media such as Facebook and MySpace.

The MT TRIC Board, including the CSHS member, attended the 2009 Montana Youth Transitions Conference, where they had a booth to provide transition resources and information. Topics presented at the conference included the Social Security System, the Vocational Rehabilitation Program, assistive technologies, and transition assessments for Individualized Educational Plans as youth begin the transition process in school. Approximately 250 attended this conference.

The CSHS supervisor met with the Administrator of the Disability Services Division in April of 2010 to learn how CSHS could become more of a presence and voice for transition services in Montana. This opportunity provided for guidance regarding additional partners and outreach opportunities through schools and disability programs in MT.

CSHS continued to provide limited support to youth receiving financial assistance for services and at regional clinics regarding transitions.

CSHS continued to work with existing partners to identify transitions resources. Options for collaboration with other partners were explored to increase CSHS services to youth in transition.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide limited support to youth receiving financial assistance for Children's Special Health Services (CSHS) and at regional clinic visits regarding health care transitions.		X		
2. Explored options to collaborate with several new organizations who serve youth in transition and their families.				X
3. A CSHS staff member is a member of the MT-TIRC Advisory Board and attends the quarterly meetings.				X
4. Continued work with existing partners to identify transition resource opportunities and funding opportunities.				X
5. CSHS continued to explore local, state and national transition resources.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHS is actively working to identify new partners to increase its collaborative efforts to address transition issues faced by CYSHCN. New funding sources have been identified and transition activities have been discussed with partners in preparation for the 2012 State Implementation Grant.

Staff from Shodair and the regional pediatric specialty clinics (RPSC) continues to work with youth ages 14-18 on transition issues by providing education, referral to services, and information on resources available in Montana.

Information on transition from health care programs such as Healthy Montana Kids (HMK) and Healthy Montana Kids Plus (HMK Plus) is sent to families when applications for financial assistance are sent.

A CSHS staff member continues to serve on the MT-TIRC Advisory Board. The board remains intact in part due to CSHS funding designated to 6 webinars focusing on transition issues such as Social Security and youth transitioning into handling their own medical affairs in adulthood.

Communication with health care payers continues to address complications that occur when youth transition to adult care/services.

CSHS has been working with the Department's staff to discuss website enhancements. CSHS is considering compiling a list of transition resources on a dedicated webpage, which will provide informational website links and other transition resource information.

The Montana Cystic Fibrosis (CF) teams have identified transition to adult care as a focus of effort.

c. Plan for the Coming Year

CSHS staff will continue to send transition information with CSHS financial assistance applications and provide information to families regarding transitioning from health care programs such as HMK and HMKP to other payment sources.

CSHS will continue to collaborate with partners and CYSHCN to promote transition services. CSHS partners such as Parents Lets Unite for Kids (PLUK, the MT Family Voices agency), the Rural Institute (Montana's Center of Excellence in Disabilities), and Summit Independent Living Center (advocacy and resource center for Montanans' with disabilities), will continue to build and promote transition programs and services.

Financial support will be offered to support continuing projects such as webinars that address transition issues, website maintenance for a transition website for youth, and an advocacy program in schools.

Other opportunities for collaboration will be explored. CSHS will continue efforts to identify organizations in other regions of the state which serve youth in transition and opportunities for expanded support of transition activities in Montana.

A new webpage will be added to the CSHS website to provide links to other sites that provide transition information and resources.

Additional funding sources will be sought to increase the capacity of CSHS to address transition and other program priorities.

CSHS will continue communicating with other CYSHCN state programs and Association of Maternal & Child Health Programs (AMCHP) about challenges and opportunities in order to help identify new opportunities to provide transition services and information to Montana youth and their families.

Shodair will continue to work with youth aged 14-18 on issues related to transition to adulthood at genetic and metabolic clinics.

Communications with healthcare payers will continue to help address issues that arise when youth transition into adult services.

A CSHS staff member will continue to serve on the MT-TIRC advisory board and will attend the annual Montana Transitions conference.

Regional CF clinic coordinators will finish a transition checklist for children and families. This

checklist will follow cystic fibrosis clients throughout the development cycle. The checklist is now in draft form and will be implemented during fall 2011 clinics.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	80	80	80	80	70
Annual Indicator	73.6	75	65.5	60.3	60.3
Numerator	12231				
Denominator	16618				
Data Source			National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	65	65	65	65	67

Notes - 2010
The source of data is the National Immunization Survey (NIS), Q3/2009-Q2/2010. Please note the 95% confidence interval is +/-7.3. The data for 2010 are not final.

Notes - 2009
The source of data is the National Immunization Survey (NIS), July 2008-June 2009 Table Data (http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_0809.htm). The data for 2009 are not yet final. Please note that the 95% confidence interval for this indicator is +/- 7.0.

Notes - 2008
The source of data is the National Immunization Survey (NIS), July 2007-June 2008 Table Data (http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_0708.htm). The data for 2008 are not yet final. Please note that the 95% confidence interval for this indicator is +/- 6.7.

a. Last Year's Accomplishments
The Montana Department of Public Health and Human Services (DPHHS) Immunization Program continued to encourage and support vaccination activities throughout the state, including:
1. Improved varicella surveillance: including using WIZRD data to review histories of chickenpox infection and concentrating efforts during outbreaks on adolescents and younger children without

2 doses of the varicella vaccine
2. Increasing Tdap/Td booster rates for children in grade 7 by encouraging active participation of school nurses and administrators, and public health nurses.
3. Increasing the DTaP immunization rate among 2-year olds.
4. Providing educational brochures regarding HPV for girls ages 9 -- 18 to schools for distribution to the parents.
5. Conducting Regional Immunization Workshops for Local Health Jurisdictions to provide updates and training.
6. Encourage testing of all pregnant women for Hepatitis B infection during every pregnancy and reporting of positive test results to state or local health departments for case management and follow up.

The Family and Community Health Bureau (FCHB) which houses the Maternal and Child Health (MCH) Coordination Section provided technical assistance and programmatic support to local health departments which selected National Performance Measure (NPM) 07. Twenty-nine counties selected NPM 07 as their focus and conducted activities to help improve immunization rates in their counties.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Increase Varicella surveillance				X
2. Increasing Tdap/Td booster rates for children in grade 7			X	
3. Increasing the DTaP immunization rate among 2-year olds			X	
4. Provided educational brochures regarding HPV for girls ages 9 -- 18 to schools for distribution to the parents		X		
5. Conducted Regional Immunization Workshops for Local Health Jurisdictions				X
6. Encouraged testing of all pregnant women for Hepatitis B infection			X	
7. Provider use of WIZRD continued to increase				X
8. The electronic import of immunization records from the Indian Health Service were conducted weekly by one Tribal Health Department				X
9.				
10.				

b. Current Activities
The FCHB developed an Immunization Activity Guide for local health departments to provide them with best practices to improve immunization rates in their counties. (See attached)

The Public Health Home Visiting (PHHV) program will assess whether infants in the program receive their two, four and six month immunizations and the PHHV provider will counsel parents on the importance of continuing scheduled immunizations for infants.

The Children and Youth with Special Health Care Needs (CYSHCN) Section will assess children who attend some pediatric specialty clinics for required immunizations and refer them to the appropriate resources.
The WIC Program will continue to encourage parents and caregivers to obtain well childcare and refer participants to eligible programs. The WIC certification form includes a check-off box for the health care provider to indicate if the child is up-to-date on immunizations, which then enables the WIC nutritionist to reinforce the importance of obtaining missed immunizations.

The DPHHS Immunization Section will partner with 57 contractors to improve the immunization

rate in Montana. The Immunization Section has monthly phone calls with all partners to provide technical assistance and programmatic support.
An attachment is included in this section. IVC_NPM07_Current Activities

c. Plan for the Coming Year
The FCHB will develop a qualitative survey for local health departments to assess state support for all performance measures including NPM 07.

The Affordable Care Act Home Visiting (ACA HV) and state Public Health Home Visiting (PHHV) programs will assess whether infants in the program receive their two, four and six month immunizations. The ACA HV and state PHHV providers will counsel parents on the importance of continuing scheduled immunizations for infants.

The CYSHCN program will assess children who attend some pediatric specialty clinics for required immunizations and refer them to the appropriate resources.

The WIC Program will continue to encourage parents and caregivers to obtain well childcare and refer participants to eligible programs. The WIC certification form includes a check-off box for the health care provider to indicate if the child is up-to-date on immunizations, which then enables the WIC nutritionist to reinforce the importance of obtaining missed immunizations.

The DPHHS, Immunization Section will partner with 53 contractors to improve the immunization rate in Montana. Contractor activities will consist of:
• Maintaining immunization records in the statewide immunization registry system.
• Coordinating and providing outreach and referrals for children identified by immunization information systems who are behind in their immunizations.
• Developing and implementing a protocol for reducing missed opportunities for vaccination (eg. Review immunization records at every visit, or eliminate missed opportunities for simultaneous vaccination).
• Meeting quarterly with key internal partners to review data provided and discuss strengths and opportunities for improvement.
• Meeting quarterly with local vaccinations for children (VFC) providers to review the data reports provided by Department of Public Health and Human Services (DPHHS) and share best practices for increasing immunization rates.
• Maintaining records received from local schools for children entering kindergarten and 7th grade, review for completeness and accuracy, and follow up on children who are conditionally attending.
• Assessing immunization records of children enrolled in daycare settings for appropriate immunization status, and notify day care providers of children who are enrolled without appropriate documentation of immunization.
• Providing follow-up in the daycare settings for children not up-to-date as required for daycare attendance.
• Ensuring the perinatal hepatitis b prevention protocol is updated to include standards developed by the centers for disease control and prevention.
• Promoting delivery of vaccination services to underinsured adolescents.

See the attached map indicating the county health departments that will be addressing NPM 7 in FY 2012.

An attachment is included in this section. IVC_NPM07_Plan for the Coming Year

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	9.6	17	16	16	17
Annual Indicator	17.6	16.8	18.6	18.9	18.9
Numerator	359	343	367	359	359
Denominator	20424	20388	19782	19015	19015
Data Source			Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	17	17	16	16	16

Notes - 2010
Data reported are for 2009. 2010 data are not yet final. They are expected to be available later in 2010.

Notes - 2009
The numerator is the number of live births reported to the Montana Office of Vital Statistics for 15-17 year old female Montana residents in 2009. The denominator is the latest mid-year population estimate (May 2010 release) for females ages 15-17 in Montana in 2009.

Notes - 2008
The numerator is the number of live births reported to the Montana Office of Vital Statistics for 15-17 year old female Montana residents in 2008. The denominator is the latest mid-year population estimate (May 2009 release) for females ages 15-17 in Montana in 2008.

a. Last Year's Accomplishments
In state fiscal year (SFY) 2009, there were 359 births to females aged 15-17 and only 2 births to females under the age of 15. From 1995 to 2007, the United States teen birth rate, for 15-19 year old females, declined by approximately 23%. During the same time period in Montana, the teen birth rate, for 15-19 year old females, declined by 12%. In 2007, 20 states had teen birth rates lower than Montana's.

The Women's and Men's Health Section (WMHS) maintained contracts and provided technical assistance with 14 Delegate Agencies (DAs), offering services in 28 locations representing all 56 Montana counties. DAs ensured that women and men of reproductive age, including adolescents, had access to comprehensive reproductive health care, education information, and services that included how to prevent unintended pregnancy. The agencies' sliding fee schedules, based on

family size and income, also ensured the affordability of these reproductive health services and supplies. In SFY 2010, the DAs served an estimated 7,331 adolescents and also provided specific outreach projects designed for adolescents at high risk for teen pregnancy and birth.

WMHS Program Specialist (PS) coordinated with a Health Education Specialist (HES), and Maternal and Child Health (MCH) Epidemiologist to distribute information to local DAs on current teen pregnancy rates and trends in the 2010 Annual Report and 2010 Teen Pregnancy Report. http://www.dphhs.mt.gov/PHSD/Women-Health/pdf/pregnancyreport.pdf

The HES organized a statewide campaign for Teen Pregnancy Prevention Month in May. Outreach packets were created that included a press release, sample letter and updated teen pregnancy rates for Montana. The State Family Planning Information and Education Committee (SFPIEC) met in June 2010 to review and plan family planning priorities: Teen Pregnancy Prevention Month, Family Involvement Month, Sexual Health Awareness Month, and the "I Know" Campaign through outreach campaigns and toolkits provided by HES.

The HES met with the Regional Training Advisory Committee (RTAC), to evaluate DAs and Region VIII Title X agencies training needs, and the March 2010 Training focused on adolescents, clinicians, and front desk staff. The HES participated in Region VIII family planning training on Reproductive Health Education in April 2010; Denver CO. The focus was on reaching adolescents through social networking.

The Office of Population Affairs (OPA) distributed funds to WMHS which allocated it to DAs for expanding male services; the Bozeman Teen Outreach & Pregnancy Prevention Project (ended May 2010); dispensed highly effective and emergency contraceptives; and expanded services targeting low income women and men, including adolescents.

WMHS supported Planned Parenthood of Montana's efforts in teen pregnancy prevention and statewide teen pregnancy coalition. Staff attended a presentation during the Montana Public Health Association Conference. WMHS continues to provide information to the public on teen pregnancy rates in Montana.
WMHS disseminated information through the online newsletter which included funding opportunities, upcoming trainings and events, and information for Title X agencies.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. WMHS continues to provide reproductive health services, technical assistance, and educational and outreach materials	X		X	X
2. WHMS distributes an on-line newsletter for all the DAs, to provide updated information on teen pregnancy rates and other relevant information		X	X	X
3. Meet and discuss materials and family planning priorities with the SFPIEC				X
4. WMHS provides toolkits for 4 educational campaign's: Let's Talk Month, Get Checked MT, Sexual Health Awareness Month, and Teen Pregnancy Prevention Month		X	X	
5. Delegate agencies provide public education and outreach on comprehensive reproductive health care services that include how to prevent unintended pregnancy			X	
6.				
7.				
8.				
9.				

10.				

b. Current Activities
WMHS contracts with 14 DAs, representing all 56 MT counties. The DAs provide reproductive health services, technical assistance, and educational and outreach materials to residents.

WMHS distributes information to local DAs on current teen pregnancy rates and trends on a yearly basis and during a conference in November 2010.

SFPIEC meets on a yearly or as needed basis to review and plan family planning priorities: Teen Pregnancy Prevention Month, Family Involvement Month, Sexual Health Awareness Month, and "Get Checked MT" HIV awareness through outreach campaigns and toolkits.

The Nurse Practitioner (NP) meets with RTAC, evaluating DAs and Region VIII Title X agencies training needs, and the March 2011 training focused on clinicians and motivational interviewing with adolescents and lesbian, gay, bisexual, transgender, questioning, and intersexed individuals. NP participated in Region VIII training on Reproductive Health Education in May 2011.

OPA funding is distributed to DAs for expanding male services; dispensing highly effective & emergency contraceptives; and expanding services targeting low income women and men, including adolescents.

WMHS received a grant to address teen pregnancy prevention utilizing evidenced based curriculum. The Request for Proposal was issued in April 2011. WMHS disseminates information through the online newsletter including funding opportunities, upcoming trainings and events, and information for Title X agencies. See the attached Action Guide.
An attachment is included in this section. IVC_NPM08_Current Activities

c. Plan for the Coming Year
Women's and Men's Health Section (WMHS) will contract and provide technical assistance with 14 Delegate Agencies (DAs), offering services in 28 locations representing all 56 MT counties. DAs will ensure that women and men of reproductive age, including adolescents, have access to comprehensive reproductive health care, education information, and services that include how to prevent unintended pregnancy. The agencies' sliding fee schedules will be based on family size and income. The sliding fee schedules will also ensure the affordability of these reproductive health services and supplies.

WMHS Program Specialist (PS) will continue to coordinate with HES, and MCH Epidemiologist to distribute information to local DAs on current teen pregnancy rates and trends on a yearly basis. SFPIEC meets on a yearly or as needed basis to review and to plan family planning priorities: Teen Pregnancy Prevention Month, Family Involvement Month, Sexual Health Awareness Month, and "Get Checked MT" HIV awareness through outreach campaigns and toolkits provided by HES.

HES will meet with RTAC, evaluating DAs and Region VIII Title X agencies training needs in fall 2011.

WMHS will continue to seek funding from the Office of Population Affairs for teen pregnancy prevention through the Personal Responsibility and Education grant. Trainings for sub-grantees will be conducted in fall 2011.

Curriculum training will cover Reducing the Risk for high school age population, and Drawing the Line for middle school population.

OPA funding will continue to be distributed to DAs for expanding male services; dispensing highly

effective & emergency contraceptives; and expanding services targeting low income women and men, including adolescents.

WMHS will continue to disseminate information through the on-line newsletter including funding opportunities, upcoming trainings and events, and information for Title X agencies.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	40	40	46	46	46
Annual Indicator	45.9	45.9	45.9	45.9	45.9
Numerator	4693	4693	4805	4773	4915
Denominator	10225	10225	10468	10398	10707
Data Source			05 06 Statewide OH Study, OPI 3rd Grade Enrollment	05 06 Statewide OH Study, OPI 3rd Grade Enrollment	05 06 Statewide OH Study, OPI 3rd Grade Enrollment
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	46	46	46	46	46

Notes - 2010
Numerator data are from a 2005-2006 school year oral health survey of third graders. The numerator was estimated using a weighted percent of 3rd graders who have received sealants. Denominator data are the number of 3rd graders enrolled in public schools for the 2009-2010 school year from the Montana Office of Public Instruction.

Notes - 2009
Numerator data are from a 2005-2006 school year oral health survey of third graders. The numerator was estimated using a weighted percent of 3rd graders who have received sealants. Denominator data are the number of 3rd graders enrolled in public schools for the 2008-2009 school year from the Montana Office of Public Instruction.

Notes - 2008
Numerator data are from a 2005-2006 school year oral health survey of third graders. The numerator was estimated using a weighted percent of 3rd graders who have received sealants. Denominator data are the number of 3rd graders enrolled in public schools for the 2006-2007 school year, from the Montana Office of Public Instruction.

a. Last Year's Accomplishments
During the 2009 -- 2010 school year, 91 schools conducted voluntary Basic Screening Survey (BSS) of children enrolled in public schools across Montana. The survey found that 39% of 3rd graders screened had received protective sealants on at least one permanent molar tooth. This does not meet the Healthy People 2010 goal of 50 percent.

The summary report on Montana's "2005-2006 Oral Health Study for Montana's Third Grade and Head Start Children" was finalized and distributed to oral health stakeholders. It was also made available to the public on the Family and Community Health Bureau (FCHB) Oral Health website http://www.dphhs.mt.gov/PHSD/family-health/oral-health/family-oralHealth-index.shtml

The FCHB Oral Health (OH) program produced oral health educational materials which provide age-appropriate materials for teachers of children in grades 1-5. Each section focuses on one grade level and provides a summary of objectives and resources as well as talking points, handouts, coloring pages, games, illustrations, and lessons. Topics include the importance of teeth and oral hygiene, tooth development, tooth decay and prevention, importance of sealants and nutrition. Allmaterials are available on the FCHB Oral Health website http://www.dphhs.mt.gov/PHSD/family-health/oral-health/family-oralHealth-index.shtml

The FCHB OH program received a Grants to States to Support Oral Health Workforce Activities award from HRSA for developing a 5-year strategic plan (which will include implementing school-linked sealant programs), increasing number of schools which provide dental career education, and increasing the dental workforce in Montana.

The FCHB offers the Open Wide program (online oral health education program) to child care providers, WIC staff and school nurses. Upon completion of the Open Wide program participants are eligible for 2 continuing education credits from Montana's Early Childhood Project. In Calendar Year 2010 over 144 participants received this training and over 12,315 toothbrushes were distributed.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Voluntary Basic Screening Survey			X	
2. Summary report on Montana's "2005-2006 Oral Health Study for Montana's Third Grade and Head Start Children" was finalized and distributed				X
3. Oral health educational materials			X	
4. Open Wide program				X
5. grant award from HRSA for oral health workforce activities				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Grants to States to Support Oral Health Workforce Activities allows for partnering with Montana State University, Area Health Education Center to increase dental recruitment and retention efforts for the state and to develop and present dental career education modules for high school students.

The Oral Health Program will continue to review and update educational materials. The materials will be promoted in communications to school nurses, public health partners, school officials and other interested parties.

The Oral Health Program will continue to offer the Open Wide program which provides oral health education to child care providers, WIC staff, and school nurses.

Collaboration with Head Start was increased and a new, uniform dental exam form was drafted for use by all participating Head Start programs in the state. This new form will allow for analysis of oral health data by site and provide valuable information to communities seeking to address oral health issues.

The Oral Health Program will release a report summarizing the accomplishments and challenges of the Access to Baby Child Dentistry (ABCD) program. Individual reports will be available for the participating health centers and a comprehensive report will be released to the general public.

School-specific reports on school-based oral health screenings conducted in the 2008-2009 and 2009-2010 school years will be distributed to participating schools and oral health screeners.

c. Plan for the Coming Year

The Grants to States to Support Oral Health Workforce Activities is a three year grant; therefore allowing the Oral Health Program to continue their partnership with Montana State University, Area Health Education Center to increase dental recruitment and retention efforts for the state and to develop and present dental career education modules for high school students.

The OH program will continue to review and update educational materials. The materials will be promoted in communications to school nurses, public health partners, school officials and other interested parties.

The OH program will continue to offer the Open Wide program which provides oral health education to child care providers, WIC staff, and school nurses.

Collaboration with Head Start will continue to implement use of a new, uniform dental exam form which will allow for analysis of oral health data by site and provide valuable information to communities seeking to address oral health issues.

The OH Program will release a report summarizing the accomplishments and challenges of the ABCD program. Individual reports will be available for the participating health centers and a comprehensive report will be released to the general public.

School-specific reports on school-based oral health screenings conducted in the 2010-2011 school year will be distributed to participating schools and oral health screeners.

The OH Program will continue to seek funding to implement school-linked dental sealant/varnish programs.

The OH Program will seek to work closely with the one county health department selected NPM 9 for the coming year. See the attachment.

An attachment is included in this section. IVC_NPM09_Plan for the Coming Year

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	4.4	4.3	4	6	6
Annual Indicator	6.2	5.6	6.2	5.6	5.6
Numerator	11	10	11	10	10
Denominator	177559	177577	178565	179583	179583
Data Source			MT Office of Vital Statistics and census estimates	MT Office of Vital Statistics and census estimates	MT Office of Vital Statistics and census estimates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	5.4	5.4	5	5	5

Notes - 2010
The data reported are for 2009. 2010 data were not available at the time of grant submittal.

Notes - 2009
Denominator data are from the updated July 1, 2009 census estimates for the population of 0-14 year olds in Montana (May 2010 release). Numerator data are the number of deaths to Montana residents 14 and under due to motor vehicle crashes, as reported to the Montana Offive of Vital Statistics. Due to the small number of events, these data are reported as a 3-year moving average (as of the 2006 data).

Notes - 2008
Denominator data are from the updated July 1, 2008 census estimates for the population of 0-14 year olds in Montana (May 2009 release). Numerator data are the number of deaths to Montana residents 14 and under due to motor vehicle crashes, as reported to the Montana Office of Vital Statistics. Due to the small number of events, these data are reported as a 3-year moving average (as of the 2006 data).

a. Last Year's Accomplishments
The rate of deaths due to motor vehicles among children 14 years and younger continues to hover around 6 per 100,000. Motor vehicle deaths are one of the leading causes of death for

Montanans of all ages, and they become the leading cause and outpace other causes around 6-12 years of age.

In April 2010, the Infant Child & Maternal Health Section (ICMHS) became a part of the Maternal and Child Health Coordination section (MCHC) of the FCHB. The Fetal, Infant, and Child Mortality Review (FICMR) Coordinator was available as a resource via phone, email, traditional mail, or in person. The state FICMR coordinator shares pertinent prevention information, current journal articles and information received from national sources related to infant and child death prevention with the local coordinators. The FICMR Coordinator participates on the Injury Prevention Coalition and the Emergency Medical Services for Children (EMSC), each charged with addressing preventable injuries.

The state FICMR Coordinator maintained contact with local FICMR Coordinators to assist with death certificate attainment, technical assistance and best practices for review and prevention. Local FICMR teams reviewed child deaths and implemented community activities related to prevention of motor vehicle deaths. Eleven County Health Departments reported a prevention activity pertaining to the prevention of deaths due to motor vehicle accidents. Activities included car seat and safety belt checks, an education campaign about "blind spots" to prevent accidents while backing up a vehicle, coordinated efforts to educate children and youth about drinking and driving, distracted driving and ATV safety, as well as motor vehicle safety while working on the farm or Hutterite colony.

One county selected NPM 10 as its focus and conducted activities to help decrease the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes.

The State FICMR Team no longer meets due to budget cuts.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. A FICMR newsletter addressing current safety practices related to seatbelt use, car seats, helmet use and public awareness to watch for kids playing by cars			X	
2. Coordination with Healthy Mothers, Healthy Babies to promote access to car seats		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The FICMR Coordinator continues to support state and community injury prevention efforts by providing educational meetings/trainings and continues to be a resource via phone, email or through in-person contact and shares prevention information with local coordinators. Current journal articles and information related to infant and child death prevention, specific to motor vehicle safety, car seat and seat belt use are sent electronically to local coordinators.

The FICMR Coordinator attended the National Conference for Child Death Review at the Center for Disease Control in Atlanta, GA. FICMR is currently evaluating the use of the CDR reporting

tool, with the intention of participating in the National CDR data collection system to better understand child deaths, including those caused by motor vehicle accidents.

The FICMR Coordinator attends quarterly EMSC Advisory Meetings and State Injury Prevention Coalition meetings to discuss prevention strategies and analyze data findings. The FICMR Coordinator is a member of the Western Regional State Child Death Review Coordinators to address deaths to motor vehicle accidents, specific to rural/frontier states.

The FICMR Coordinator works with the MCHC Supervisor, MCH Epidemiologist, Vital Statistics, Injury and Prevention Coordinator, and other members of the Injury Prevention Coalition.

c. Plan for the Coming Year

The FICMR Program will continue to support community and state efforts in targeting the rate of deaths to children aged 14 and younger caused by motor vehicle crashes. The plan to target the rate of deaths caused by motor vehicle crashes is to 1) work collaboratively with local coordinators, especially those in counties experiencing higher rates, 2) work collaboratively with other agencies to target motor vehicle crashes, and 3) develop resources and tools to better understand why motor vehicle crashes occur and what prevention activities and/or policies will reduce rates in Montana.

The FICMR Coordinator will work collaboratively with local coordinators to address the rate of deaths due to motor vehicle crashes by focusing on motor vehicle and transportation safety at the local FICMR coordinator training and meetings. Unintentional motor vehicle traffic crashes and unintentional other land transport are the leading causes of death among Montana youth. Goals are to implement local policies to address motor vehicle safety and enforce safety on the road. Local FICMR Teams will continue to review child deaths and implement community activities related to prevention of deaths attributed to motor vehicle crashes. The FICMR Coordinator will assist in the sharing of practices and prevention activities to assure coordination and collaboration between counties.

The FICMR Coordinator will continue to attend quarterly EMSC Advisory Meetings and State Injury Prevention Coalition meetings to discuss prevention strategies and analyze data findings. The State FICMR Coordinator will share prevention information with local coordinators via email or trainings to assist local FICMR teams in developing community level prevention activities. The FICMR Coordinator is a member of the Safe States Alliance and will participate in trainings.

The FICMR Coordinator is a member of the Western-States Child Death Review Coalition, a group that meets via conference call once a month to strategize around a variety of topics. Plans to implement the Child Death Review (CDR) Data Reporting system (1/1/2012) will improve national and local data, as well as prevention activities, related to deaths of children aged 14 years and younger caused by motor vehicle crashes.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	26	29	54	54	57
Annual Indicator	49.3	52.1	52.9	58.6	55.4

Numerator					
Denominator					
Data Source			National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	57	57	58	58	58

Notes - 2010
The data reported for 2010 are National Immunization Survey data for children born in 2007. The data are not yet final. The confidence interval for this rate is +/- 7.7.

Notes - 2009
The data reported for 2009 are National Immunization Survey data for children born in 2006. The confidence interval for this rate is +/- 6.4.

Notes - 2008
The data reported for 2008 are National Immunization Survey data for children born in 2005. The data are final. The confidence interval for this indicator is +/- 6.1.

a. Last Year's Accomplishments
The MSPIRIT computer system has been rolled out for over a year. The system is still evolving as new partners are added and changes and modifications are made to the system. Data reporting is now being reviewed as a complete year's information is available.

The state Breastfeeding Coordinator (BC) worked with the MSPIRIT Users Subcommittee on modifying data fields and layout of the system's breastfeeding reports. This work will continue into the current year.

Two local program staff attended the USDA "Loving Support" breastfeeding training. They presented a pared down version of the training at the WIC Day of the Spring Public Health Conference (SPHC) in April 2010. The sessions build staff competencies for promoting and supporting breastfeeding. This included using the advantages of the breastfeeding food packages in conjunction with that promotion and support. These sessions and two others at the SPHC were eligible for Continuing Education Units (CEUs) with recognized breastfeeding organizations.

An additional four local programs were awarded Breastfeeding Peer Counselor grants for FFY 2010. They will continue with grants in FFY 2011. Three of the programs, Gallatin, Flathead and RiverStone represent about 20% to 25% of our annual participation. The Northern Cheyenne WIC Program also was awarded a grant, expanding the program to a second American Indian local program in Montana. The extra training funds were used to train staff as Certified Lactation

Counselors or to attend breastfeeding conferences.

Additional Breastfeeding Peer Counselor Program funds were earmarked for a training intended for the Breastfeeding Peer Counselors (BPC) and their supervisors. The training was carried out in December 2010. (see attached)

The weekly WIC newsletter was utilized to provide information about various breastfeeding conferences and trainings. This method allowed distribution of the information to not only direct service local WIC staff, but also to their supervisors and other interested parties.

The BC continued to be active in the Montana State Breastfeeding Coalition and attended the United States Breastfeeding Committee's 3rd National Conference for State/Territory/Tribal Breastfeeding Coalitions.

Montana implemented the Farm Direct Program which combines redemption activities of the WIC Fruit and Vegetable benefit and the WIC Farmers' Market Nutrition Program (FMNP) benefit. Authorized farmers selling their own locally grown produce sign one agreement and can redeem both benefits at any location where they normally sell their produce. The agreement is for three years with annual training. The authorized produce list is the same for both types of benefits. (See attached)

The What Incredible Choices Toolkit, a nutrition education tool kit emphasizing farmers' markets, was developed. Training for this toolkit was provided at the 2010 SPHC. The toolkit was also posted on the Montana WIC webpage at http://wic.mt.gov and at http://wicworks.nal.usda.gov/nal under shared resources.
An attachment is included in this section. IVC_NPM11_Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued Breastfeeding Peer Counselor Funding, Tech Assist to Locals	X			
2. Monitoring of Four BPC				X
3. Involvement with MT State Breastfeeding Coalition				X
4. Use of in-house newsletter to communicate training opportunities				X
5. Determined standards for new automated system and breastfeeding dyad food package assignment				X
6. Training on new food package including new breastfeeding food packages and relationship of breastfeeding level and supplemental formula, Loving Support (breastfeeding support)				X
7. Ordered breast pumps for distribution by local programs		X		
8.				
9.				
10.				

b. Current Activities
Hill, Lewis and Clark, and Silver Bow counties are starting the WIC Breastfeeding Peer Counselor Program (BPCP). They will provide BPC services to approximately 400 more pregnant or breastfeeding women. In the 2011 BPCP local contracts, the local programs were given three measurable indicators from which to choose two to report for their program. The three choices were: 1) percent of pregnant women contacted by a breastfeeding peer counselor, pre- and post-data for the year; 2) percent of women who have more than 3 actual contacts with a breastfeeding peer counselor during the fiscal year; or 3) percent of women exclusively

breastfeeding (WIC definition) at 3 months post delivery during the fiscal year. Training for BPCP and the BPC Supervisors was held November 30th and December 1st.

The State BC will be revising the BPCP monitoring tool due to the changes in monitoring with the implementation of the MSPIRIT automated system.

Announcements of upcoming breastfeeding conferences and trainings are included in the weekly WIC newsletter e-mail to all WIC staff and interested parties.

Montana joined the Western States Contracting Alliance (WSCA) breastpump contract. It is unknown at this time if food funds will be available to purchase breastpumps, but WSCA was available to join and in the current contract had several options of breastpumps available.

The BC participates in the Montana State Breastfeeding Coalition.

c. Plan for the Coming Year

Montana plans to maintain the 12 Breastfeeding Peer Counselor Projects at the local level. The statistical measures the local programs are to submit at the end of 2010 contract will be reviewed and analyzed. Subsequent year's activities will be measured against the benchmark to evaluate improvement.

The BC is planning to attend the Loving Support Training to be held in Denver in November 2011. She is also planning to attend the US Breastfeeding Committee Conference in August 2012. The information garnered from these trainings, especially the Loving Support Training will be used in future trainings for the BPC and their supervisors. Method of delivery of trainings will be determined based on available funding.

Work with the Reports Subcommittee of the MSPIRIT Users Group will continue. The committee has submitted requests to fix a number of reports and also enhancement requests. The changes made as a result of these requests will be reviewed as completed and the committee will determine if they are acceptable.

The BC plans to continue to participate in the Montana State Breastfeeding Coalition.

Three local health departments will focus on NPM 11 in FY 2012. See the attachment.
An attachment is included in this section. IVC_NPM11_Plan for the Coming Year

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	92	92	94	94	94
Annual Indicator	90.0	93.1	93.0	97.7	98.3
Numerator	11107	11403	11669	11448	11447
Denominator	12339	12249	12551	11719	11648
Data Source			MT newborn hearing screening system, Hi-Track	MT newborn hearing screening system, Hi-Track	Newborn Hearing Screening System and birth records

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	98.5	98.5	99	99	99

Notes - 2010
The numerator data source for this measure is HI*TRACK, the Newborn Hearing Screening Program software. The numerator includes hearing screenings for infants born in hospitals in Montana. The denominator is from the Montana Office of Vital Statistics and includes births that occured in Montana hospitals in 2010. It does not include births to Montana residents that occurred in hospitals out of state. As of 2009, the data reported are only for infants born in hospitals, to more closely correspond with the guidance for reporting on this performance measure. The data entered for 2010 are provisional.

Notes - 2009
The numerator data source for this measure is Hi-Track. The numerator includes hearing screenings for infants born in hospitals in Montana. The denominator is from the Montana Office of Vital Statistics and includes births that occured in Montana hospitals in 2009. It does not include births to Montana residents that occurred in hospitals out of state. The data were updated for the 2011 submission to reflect only hospital-based births.

Notes - 2008
The numerator data source for this measure is Hi-Track. The numerator includes hearing screenings for infants born to Montana residents in Montana. The denominator is from the Montana Office of Vital Statistics and includes births to Montana residents that occured in Montana in 2008. It does not include births to Montana residents that occurred out of state. 12,178 (97%) of Montana's calendar year 2008 birth cohort were born in hospitals, approximately 2.5% were born with professional attendants, and .5% were born at home without professional attendants. Of those born in hospitals, 96% were screened prior to hospital discharge.

a. Last Year's Accomplishments
Montana's Universal Newborn Hearing Screening and Intervention (UNHSI) program continued to strive to achieve the 1-3-6 plan of the EHDI National Goals: Goal 1--all newborns will be screened for hearing loss before 1 month of age, preferably before hospital discharge; Goal 2--all infants who screen positive will have a diagnostic audiologic evaluation before 3 months of age; Goal 3--all infants identified with hearing loss will receive appropriate early intervention services before 6 months of age (medical, audiologic, and early intervention). The UNHSI program works in partnership with the Office of Public Instruction (OPI), the Montana School for the Deaf and the Blind (MSDB), local hospitals, midwives, and audiologists to achieve these goals.
Newborn hearing screening was performed at all 29 Montana birthing facilities and results were reported to the state UNHSI program for monitoring. For reporting purposes all newborn screening results were matched to birth certificate data. Upon referral, based on screening results, six pediatric audiologists reported diagnostic testing results to the program.

The MCH Block Grant objective for reporting year 2009 was 94% and 93.9% was achieved. Montana had 12,204 births in calendar year 2009. A total of 11,697 newborns received hearing screenings and of those babies 214 had "refer" results indicating the need for diagnostic evaluations. Of those infants whose screens indicated the need for follow-up, only 36 were documented to have received audiological diagnostic testing. Twenty-five of these infants were diagnosed as deaf or hard of hearing.

The UNHSI coordinator continued to provide technical assistance to hospitals, audiologists, and midwives to ensure compliance with state law. The program continued to provide tracking software and contracted for Help Desk services for use by birthing facilities and audiologists. The UNHSI Coordinator provided monthly feedback to all 29 birthing facilities on screening records to ensure that appropriate follow-up was completed based on screening results. A letter was sent to the primary care physician of each infant without a "pass" result on his or her hearing screening along with contact information for the five audiologists who are qualified to perform pediatric audiologic assessments in Montana.

The Montana Hearing Conservation Program audiologists under contract with OPI continued to provide free hearing screening to infants born outside of hospitals in accordance with the on-going agreement established between the UNHSI Coordinator and OPI.

All infants diagnosed as deaf or hard of hearing were electronically referred by the UNHSI Coordinator to the Montana School for the Deaf and Blind for monitoring and provision/coordination of intervention services. Children's Special Health Services (CSHS) and the MSDB also collaborated to develop program software within the CHRIS database to record and track services provided to children who are diagnosed as deaf or hard of hearing.

The UNHSI Coordinator publicized the 2009 Stars report for all birthing facilities. (See attached) The UNHSI Coordinator also provided feedback to midwives on their compliance with reporting requirements to the UNHSI program.
The UNHSI program provided local screening partners with newborn hearing screening brochures, posters, rack cards, and screening report forms containing milestones for language development for distribution to the parents prior to discharge. Program educational materials were distributed to pediatricians, family practice doctors, and midwives.

UNHSI Grant funding supported 30-second advertising spots on cable television in the seven largest service areas to increase awareness of the importance of newborn hearing screenings. The CDC's Early Hearing Detection and Intervention (EHDI) grant funding continued to support UNHSI program efforts to provide intensive quality assurance on all screening data by conducting on-site visits with all local partners who screen newborns or perform diagnostic assessments over the three-year period of 2008 through 2011. EHDI grant funding was also used to enhance the CHRIS database system with the goal of increasing the program's ability to track diagnoses, continuing assessments, and intervention services for deaf or hard of hearing children.
An attachment is included in this section. IVC_NPM12_Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Link newborn hearing screening data with birth certificate data				X
2. Continue to provide tracking software and contract for Help Desk technical assistance for use by birthing facilities and audiologists.				X
3. Track newborn hearing screening and audiological assessment results from the tracking software and communicate the results to screening and assessment partners statewide.			X	

4. Electronically refer infants diagnosed as deaf or hard of hearing to the Montana School for the Deaf and the Blind within six months of each child's birth.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The UNHSI program continues to collect hearing screening data on all infants born in Montana's birthing facilities each month. Feedback is provided to make sure that all screening information is submitted and that there is follow up on infants who do not pass inpatient screens or infants not receiving an inpatient screen. The program continues to work with out-of-state hospitals to access screening information on infants who have been transferred out of state.

Primary care physicians are contacted by the UNHSI coordinator to ensure follow-up on infants with "refer" screening results. Audiologist's submissions of diagnostic testing results are monitored to make sure any infant diagnosed with a hearing loss is electronically referred to the MSDB.

Quality assurance visits to hospitals continue to ensure proper documentation and reporting to the UNHSI program and evaluate facility screening protocols. Feedback is provided to improve reporting accuracy and compliance with state law.

Educational materials continue to be provided to program partners.

Funding continues to help provide updated equipment to hospitals.

To obtain funding to continue program activities, the UNHSI coordinator submitted grant applications for the UNHSI grant and the EHDI grant.

c. Plan for the Coming Year
The Montana UNHSI program will continue collecting data on all infants receiving newborn hearing screenings and providing feedback to birthing facilities, midwives, and audiologists to increase the number of infants receiving newborn hearing screenings and ensure that each infant who has a "refer" result on inpatient screening receives appropriate follow-up as indicated. Electronic referrals to the Montana School for the Deaf and the Blind will continue to be made for all infants who receive a diagnosis of deaf or hard-of-hearing upon receipt of a signed consent form indicating that the parents wish to have the infant's information shared.
Collaboration with hospitals, audiologists, midwives, primary care providers, OPI, and MSDB will ensure the UNHSI program continues to increase the number of infants who are receiving newborn hearing screenings in Montana. Input from a hearing champion from the Montana American Academy of Pediatrics and a volunteer parent advisor will be valuable in planning and evaluating future program goals and objectives.

The program will continue to provide reporting software for newborn hearing screening results and diagnostic testing to all Montana birthing facilities and pediatric audiologists--and will continue the process of upgrading hospitals to the current version of the software. Help Desk access for all users of the software will continue to be funded by the program to ensure accurate documentation of all newborn hearing screenings and any diagnostic testing results.

Funding from the UNHSI grant will be used to help provide updated screening equipment to hospitals and diagnostic equipment will be purchased for an audiologist in eastern Montana to

help increase access to services for infants in that part of the state.

The UNHSI program will continue to provide educational materials to hospitals, midwives, pediatricians, and family practice doctors.

On-site quality assurance visits will continue--including hospitals, audiologists, and midwives-- in order to monitor and improve reporting of screening results and diagnostic testing. Targeted on-site QA visits will be done with a team including the UNHSI coordinator, the MSDB consulting audiologist, a nurse consultant, and an MCH epidemiologist. The QA visits will provide comprehensive evaluation of data and procedures to identify challenges and successes in meeting the reporting requirements required by state law.

The UNHSI coordinator will attend statewide meetings including the annual Montana Hospital Association meeting, the Montana AAP meeting, and the annual Montana Audiology Guild meeting to increase awareness of the issues identified through 2010 newborn hearing screening data analysis. The UNHSI coordinator will report on the causes of loss to follow-up (LTFU) and suggest solutions as well as get input from these partners on this issue.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	16	16	14	13	11
Annual Indicator	16.2	14.8	14.2	11.9	11.1
Numerator	37000	35686	34417	28863	26868
Denominator	228000	241206	242716	241672	242453
Data Source			US Census CPS Table Creator II	US Census CPS Table Creator II	US Census; CPS Table Creator II
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	11	11	10	10	10

Notes - 2010
The data source for this is the US Census CPS Table Creator II. The CPS data were collected in 2010 for health insurance coverage in 2009. The data for 2010 will be collected in 2011 and become avilable in 2012 for health insurance coverage in 2011. The numbers reflect the estimated percent of children under 19 years of age who were not covered by public or private health insurance.

Notes - 2009
The data source for this is the US Census CPS Table Creator II. The CPS data were collected in 2009 for health insurance coverage in 2008. The numbers reflect the estimated percent of children under 19 years of age who were not covered by public or private health insurance.

Notes - 2008
The data source for this is the US Census CPS Table Creator II. The CPS data were collected in 2008 for health insurance coverage in 2007. The numbers reflect the estimated percent of children under 19 years of age who were not covered by public or private health insurance.

a. Last Year's Accomplishments
The percent of children in Montana without health insurance varies slightly depending on the data source, but the Henry J. Kaiser Family Foundation: State Health Facts (2008-2009) indicates 11 percent of MT children were without health insurance compared to 10 percent nationally.

The Healthy Montana Kids (HMK) program was implemented October 1, 2009 and expanded eligibility to families under 250% of the federal poverty level. The Healthy Montana Kids Plan covers kids by: 1) expanding eligibility for the Children's Health Insurance Program (CHIP) and Medicaid children's coverage; 2) offering premium assistance to eligible parents who add children as dependents to their employer-sponsored health plan; 3) using "enrollment partners" to actively enroll eligible kids; and 4) using federal matching funds to pay most of the cost. The HMK program has two levels: Healthy Montana Kids Plus (same program as Medicaid) and Healthy Montana Kids (same program as CHIP). HMK is a free or low-cost health coverage plan. The plan provides health coverage to eligible Montana children and teenagers up to age 19. A child can qualify for HMK based on family size and income. This program not only increased the number of children in the state with health insurance, but also reduced the number of children who fell through the gaps between Medicaid and CHIP eligibility. Healthy Montana Kids and Healthy Montana Kids Plus were intended to facilitate continuous coverage of children whose families are under 250% of the federal poverty level, whereas previously coverage may have fluctuated if children's eligibility shifted from Medicaid to CHIP or vice versa.

In SFY 2009, Healthy Montana Kids (CHIP) had 25,298 participants under age 20 enrolled in the program and Healthy Montana Kids Plus (Medicaid), had 63,519 participants under age 20.

The HMK program continued its efforts to increase the number of children enrolled in the Healthy Montana Kids program. Children with health coverage have greater access to preventive and acute health care services. HMK continued to work towards its goal of improving the health of Montana families.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Montana Kids provided quality, comprehensive insurance coverage for Montana children		X		
2. Healthy Montana Kids expanded and coordinated coverage for uninsured children under Medicaid and CHIP		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
CHIP and Medicaid will continue their efforts to increase the number of children enrolled in the Healthy Montana Kids program.

The FCHB will use the National Survey of Children's Health to establish a baseline for any local health departments selecting National Performance Measure 13. The FCHB will also assist any local health departments selecting this performance measure in developing and implementing activities which will increase the percentage of children with health insurance and/or participating in Healthy Montana Kids.

In October 2010, the Primary Care Office (PCO) collaborated with the Primary Care Association (PCA) and HMK to create information about MT's Community Health Center locations and the National Health Service Corps sites, which was distributed in a HMK monthly mailing to families. The contact information includes how to access one of these medical care providers. (See the attachment)

Children's Special Health Services (CSHS) monitors the number of children with special health care needs (CSHCN) served by CSHS with a source of health care coverage. CSHS refers, links, and counsels families to available sources of health care coverage such as Medicaid, State Children's Health Insurance Program, Caring for Children Program and Comprehensive Health Association of ND (CHAND) as well as to other assistance programs.

WIC continues to ensure that families are referred to Healthy Montana Kids or Healthy Montana Kids Plus.

An attachment is included in this section. IVC_NPM13_Current Activities

c. Plan for the Coming Year

CHIP and Medicaid will continue their efforts to increase the number of children enrolled in the Healthy Montana Kids program. Both parties will continue to work towards their shared goal of improving the health of Montana children.

The FCHB will use the National Survey of Children's Health to establish a baseline for any local health departments selecting National Performance Measure 13. The FCHB will also assist any local health departments selecting this performance measure in developing and implementing activities which will increase the percentage of children with health insurance and/or participating in Healthy Montana Kids.

Families will be required to apply for Healthy Montana Kids or Healthy Montana Kids Plus prior to eligibility determination for CSHS services. This will allow families to have more comprehensive healthcare coverage. Families who apply for HMK or HMK+ who have a CSHCN will be offered referral to services through the CSHS program.

The Primary Care Office (PCO) will continue to work with the Primary Care Association and Healthy Montana Kids on updating the information about Montana's Community Health Center locations and the National Health Service Corps sites for ongoing distribution in HMK mailings.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	25	30	30	29	31
Annual Indicator	32.5	33.6	33.7	33.3	40.0
Numerator	3629	3706	3876	3957	5099

Denominator	11169	11029	11492	11878	12744
Data Source			WIC Program Enrollment	WIC Program Enrollment	WIC Program Enrollment
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	31	31	31	31	31

Notes - 2010
The source is the Montana State WIC Program. Data are for FFY 2010. The increase in the indicator for 2010 is believed to be due to a change in data systems. Some records may be duplicated. As a result, the objective was not increased based on the 2010 data. Montana will reassess the objective next year when a full year of data from the new data system will be available.

Notes - 2009
The source is from the MT State WIC Program. Data are for FFY 2009.

Notes - 2008
The reported denominator and numerator includes all children ages 2-5 enrolled in WIC during '08 starting 01/01/08 and ending 12/31/08. The numerator reflects all children with risk codes 16 and 17.

Although there was a fairly large increase in the percent of children ages 2 to 5 years receiving WIC services with BMI at or above 85th percentile from 2005 to 2006, since then there have been smaller but steady percentage increase reported by the WIC Program. The large change from 2005 to 2006 could be related to changes in the way the data are collected.

a. Last Year's Accomplishments
In 2009 Pediatric Nutrition Surveillance System (PedNSS) Montana data, the percent of children equal to or greater than age 2 to 5 years who had a Body Mass Index at or above the 85th percentile and less than the 95th percentile was 15.8. The percentage of children equal to or greater than age 2 to 5 years who were defined as overweight by being at or greater than the 95th percentile was 12.5. This is only a slight change from the 2008 PedNSS Montana data which was 16.0 and 12.4 respectively.

The PedNSS data submitted by WIC is collected from the automated system which is now MSPIRIT. This system identifies the anthropometric risks of at-risk of overweight and overweight using CDC growth criteria. A report in MSPIRIT will also count the number of participants that were assigned these nutrition risk codes at certification.
Local WIC staff collected children's weight and height measurements at each certification, which determined the child's body mass index (BMI). Parents of a child determined to be overweight or obese status were provided additional WIC counseling as requested by the family at future WIC appointments.

The new WIC food packages have been in place for over a year. They continue to reflect the Dietary Guidelines with more fiber-rich choices, fruits and vegetables, and low-fat foods. In

recent investigation of redemption rates, it was noted that the WIC fruit and vegetable benefits redemption rate was lower than expected, even with the option to use them with local farmers. (see attached Food List)

Montana implemented the Farm Direct Program which combines redemption activities of the WIC Fruit and Vegetable benefit and the WIC Farmers' Market Nutrition Program (FMNP) benefit. Authorized farmers selling their own locally grown produce sign one agreement and can redeem both benefits at any location they normally sell their produce. The agreement is for three years with annual training. The authorized produce list is the same for both types of benefits. Farm Direct was established to allow participants to be able to cash their WIC Fruit and Vegetable benefits with local authorized farmers. The WIC FMNP was already in place, but if both programs operated separately then it would be more difficult for participants and farmers to remember the requirements for each program. The reduction in different "rules" was to encourage participants to utilize their local farmers, especially during the seasons when fresh produce was so readily available. This also resulted in an increase in locations where participants could redeem either benefit.

An infrastructure grant was implemented at the end of September 2010. Local programs were given small grants to promote fruits and vegetables, thermal grocery bags with a fruit and vegetable theme and a Healthy Harvest Cookbook. The product items could be used in nutrition education, outreach and as incentives.

Other funds from the infrastructure grant were utilized to develop and produce a toolkit for local program staff with a theme of "What Incredible Choices." The toolkit was provided to all local programs for use in promoting fruits and vegetables.

Eat Right Montana (ERM) newsletters and child nutrition conference information were distributed through the weekly WIC newsletter which is sent to all direct services local program staff, their supervisors and other interested parties.

An additional four local programs were awarded Breastfeeding Peer Counselor grants for FFY 2010. They will continue with grants in FFY 2011. Three of the programs, Gallatin, Flathead and RiverStone represent about 20% to 25% of our annual participation. The Northern Cheyenne WIC Program was also awarded a grant and expands the program to a second American Indian local program in Montana.

Additional Breastfeeding Peer Counselor Program (BPCP) funds were earmarked for a training intended for the Breastfeeding Peer Counselors (BPC) and their supervisors. The training was carried out in December 2010.
A WIC Futures Study Group (WFSG), composed of lead local public health officials, local program, and state WIC Staff, was formed during 2008 and met in May 2010. The WFSG discussed a number of topics including, the current and future WIC funding allocation formula, program direction, and how to provide quality WIC services into the future. The minutes of this meeting are available at http://wic.mt.gov
An attachment is included in this section. IVC_NPM14_Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Local staff weigh and measure infant and child participants	X			
2. VENA questions determined and incorporated into automated system				X
3. Continued funding for BPC	X			
4. Training of staff on Loving Support (breastfeeding support)				X
5. WIC Futures Study Group activities				X

6. Distribution of ERM Healthy Families Newsletter			X	
7. Involvement with Chronic Disease/Obesity Task Force and with the MT State Breastfeeding Coalition				X
8. Train staff on significant changes to new food packages, less fat, more whole grains, fruits, vegetables and fiber				X
9.				
10.				

b. Current Activities

WIC staff and a contractor will be researching nutrition education materials available as on-line activities or other media.

Infants and children continue to be weighed and measured for WIC certification and when appropriate.

Children at a BMI greater than the 85th percentile may be referred to a Registered Dietitian for high-risk nutrition follow-up.

The BPCP expanded to 12 local programs with the addition of programs in Hill, Lewis and Clark, and Silver Bow WIC Programs. This increases access to a breastfeeding peer counselor for pregnant and breastfeeding WIC participants to about 2700 statewide.

Data on the WIC fruit and vegetable benefit and the WIC FNMP benefit redemption rate at grocers and farmers was given to local programs. Local programs were encouraged to find ways to best promote and educate their participants on the use of the two types of benefits.

This summer is the 2nd season for Farm Direct which authorizes farmers selling Montana grown produce at farmers' markets, roadside stands and other locations where they sell their produce. Increased consumption of fresh fruits and vegetables can replace less nutrient dense foods in a participant's diet.

Funding to develop local staff training for competencies in VENA was not received due to the Federal continuing resolution this fiscal year. Plans are to repeat the request next year. The competencies would include discussion on child weight issues.

c. Plan for the Coming Year

Montana WIC will purchase Food for Thought: Eating Well on a Budget, a nutrition education packet and DVD created to engage both kids and parents, for use by local staff with participants. It will provide information on how families can shop wisely and make healthy food choices on a budget; the value and importance of breastfeeding; the healthy quality and variety of the WIC food packages; and easy-to-follow recipes the family can enjoy. The packet and DVD were created as a joint project between Sesame Street and the National WIC Association.

Montana WIC will implement one year certifications for children. This may result in less frequent weighing and measuring between certification because with the implementation of this option, the delivery method of nutrition education to low-risk participants is being reviewed along with various types of resources. Resources being reviewed will also include those addressing healthful eating and being physically active.

The redemption rates of the WIC Fruit and Vegetable Benefit and the WIC FMNP Benefit were reviewed. The rates were lower than expected whether at grocery stores or farmers. At the Family and Community Health Conference (FCHC) WIC Day, local program staff were encouraged to develop nutrition education methods and activities that would work in their community to promote the use of these two benefits. The redemption rates will be monitored in Spring 2012.

Montana WIC plans to work with the Nutrition and Physical Activity Program on joint projects that promote physical activity, healthy eating behaviors and lifestyle choices. This is in the early stages of planning and definite projects have not been selected.

Two county health departments selected NPM 14 for FY 2012. (see attached)

An attachment is included in this section. IVC_NPM14_Plan for the Coming Year

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	15	15	14	14	14
Annual Indicator	15.9	15.9	15.0	13.4	13.4
Numerator	1668	1668	1893	1630	1630
Denominator	10509	10509	12595	12155	12155
Data Source			Live birth data, MT Office of Vital Statistics	Live birth data, MT Office of Vital Statistics	Live birth data, MT Office of Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	13	13	13	13	13

Notes - 2010
The data reported are for 2009. 2010 data were not available at the time of grant submittal.

Notes - 2009
The numerator and denominator include births to Montana residents that were reported to the Montana Office of Vital Statistics. The denominator does not include women with unknown smoking status in the third trimester. This indicator is believed to be an under-report of the actual number of women smoking during the last trimester.

Notes - 2008
These data are collected and reported by trimester of pregnancy, not month of pregnancy. 2008 is the first year smoking status has been available from the birth record by time period of pregnancy. The numerator and denominator include births to Montana residents that were reported to the Montana Office of Vital Statistics. This number is believed to be an under-report of the actual number of women smoking during the last trimester.

a. Last Year's Accomplishments
In April 2010, the Infant Child & Maternal Health Section (ICMHS) became part of the Maternal and Child Health Coordination section (MCHC) of the FCHB. The Public Health Home Visiting (PHHV) Nurse Consultant position now reports to the MCHC Section Supervisor. The PHHV Nurse Consultant continues to support state and community PHHV sites by serving as a resource via phone, electronically and with in-person contacts. Current information related to smoking rates and cessation during pregnancy is forwarded to PHHV home visitors.

The Family and Community Health Bureau (FCHB) funded 16 PHHV programs until 7/1/2010 when Northern Cheyenne declined a continuing contract. The remaining 15 PHHV programs continued to promote the Montana Tobacco Quit Line and other tobacco cessation resources to tobacco using women who were pregnant or primary care givers of infants.

Funding for the six enhanced PHHV sites ended in December 2009. Five of the six enhanced PHHV sites continued to be PHHV sites but one site ceased to provide PHHV activities. The five continuing sites were bound by the contract discussed in the following paragraph.

In the state PHHV site contracts which began on 7/1/2010 with 15 sites, PHHV home visitors were asked to assess and monitor the High Risk Pregnant Woman's (HRPW) smoking and other tobacco use status by following "…The U.S. Preventive Services Task Force (USPSTF) Tobacco Cessation Counseling Guide sheet assessment tool at least at intake for the HRPW and High Risk Infant (HRI)." The home visitors had been taught about the USPSTF guidelines in three webinars presented by the Montana Tobacco Cessation program during January and February 2010. PHHV clients received information on the effects of tobacco during pregnancy from the PHHV home visitors.

The PHHV Nurse Consultant collaborated with Montana Tobacco Use Prevention Program (MTUPP) to provide information for PHHV staff and other public health staff on tobacco cessation strategies for pregnant women.
PHHV sites began entering PHHV client data elements into the common electronic data system as of July 1, 2009. Data on outcomes related to pregnant women smoking, other tobacco use, cessation and referrals to cessation resources were collected 1 July-31 December 2009 by all of the PHHV sites. Thirty-four percent of PHHV women (n=109) self-reported smoking during pregnancy. Twenty-three percent of smoking PHHV women (n=37) reported smoking during the last three months of pregnancy. Thirty-five percent (n=13) reported quitting smoking during pregnancy. The findings for each site were compared to the data submitted from all sites and a report was given to each site during the visits discussed below.*

Between 2/22/2010 and 8/4/2010, all sites received a nurse consultant visit. In addition to feedback about the data submitted electronically as discussed above, record reviews were done on randomly selected client charts. One item reviewed by the site visitor was whether or not it was noted in each chart that the pregnant woman or infants' primary care giver had tobacco use assessed. In pregnant women charts, 83% of the charts clearly noted tobacco assessment was done. The record review findings were sent to each visited PHHV site.
*Represents data collected by local PHHV sites and submitted to DPHHS for clients who had intake and outcome during 1 July 2009 through 31 December 2009.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provision of PHHV to high-risk pregnant women and infants	X			
2.				
3.				
4.				
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities
SFY 2011 contracts include the requirement, under services to be provided, "Increase the percentage of PHHV clients who abstain from smoking and other tobacco use during pregnancy." Home visitors are asked to follow The U.S. Preventive Services Task Force Tobacco Cessation Counseling Guidesheet at intake of clients to assess tobacco use and plan intervention for those who use tobacco.

The FCHB funds 15 PHHV programs, which promote the Montana Tobacco Quit Line through information and referrals for their pregnant women and infant/family units. The PHHV home visitors also refer clients to other community cessation programs. (see attached)

Since SFY 2010, all the PHHV sites are visited at least once during each SFY year by a PHHV Nurse Consultant.
PHHV sites enter PHHV client data elements into a common electronic data system. Data on outcomes related to pregnant women using tobacco products, cessation of tobacco use, and referrals to cessation resources are collected by all of the PHHV sites. Quality assurance checks are conducted and site-specific reports are compiled and sent back to each site.

The PHHV clients receive information from the PHHV home visitor on the effects of tobacco and secondhand smoke during pregnancy and on the infant.

The PHHV Nurse Consultant collaborates with MTUPP to provide information for PHHV staff and other public health staff on tobacco cessation strategies for pregnant women.
An attachment is included in this section. IVC_NPM15_Current Activities

c. Plan for the Coming Year
During the coming year, Montana will administer funding to local health departments for home visiting efforts. The state funded Public Health Home Visiting (PHHV) administration of funds from DPHHS to fourteen county and one tribal health department will continue and the Affordable Care Act (ACA) Maternal Infant Early Childhood Home Visiting (MIECHV) program will begin in one county using the Parents as Teachers (PAT) evidenced-based model for home visiting.

Both of the home visiting programs will assess for and intervene in smoking by adult clients. The assessment methods are discussed below in the description for each program. Referrals are usually made to the Montana Tobacco Usage Prevention Program (MTUPP) another DPHHS entity. Other tobacco cessation sites are the recipients of referrals from home visitors and sometimes clients, based on individual assessment, are referred to psychological treatment services or private physicians for smoking cessation.

The state contract with the fourteen county and one tribal health department will require the site visitors to assess tobacco use and intervene with adults who smoke in situations where fetuses and children may be compromised. The proposed contract language is as follows: Encourage HRPW/PHHV clients to abstain from smoking and other tobacco use at or before the third trimester of their pregnancy through the end of their pregnancy and make referrals for cessation as needed.

Home visitors are required to assess and intervene using the United States Prevention Task Force guidelines and the contract language is as follows:
For each HRPW client the following required, standardized screening and/or assessment tool …

will be administered and the results will be entered into the client's PHHV … electronic record

Cessation Counseling Guidesheet at least at intake for the HRPW and High Risk Infant (HRI). The U.S. Preventive Services Task Force Tobacco Cessation Counseling Guidesheet is located at:
http://www.ahrq.gov/clinic/uspstf09/tobacco/tobaccosum2.htm

ACA MIECHV funds will allow the selected high-risk community to serve approximately 50 families. MIECHV benchmarks and constructs require gathering of data related to maternal child health and pregnancy outcomes.
… States are required to collect data on all constructs listed below each benchmark area… Improved Maternal and Newborn Health [Benchmark]… Constructs that must be reported for this benchmark area (all constructs must be measured that are relevant for the population served)… Definition of quantifiable, measurable improvement… For pre- and post-natal parental use of alcohol, tobacco, or illicit drugs improvement is defined as rate decreases over time.

At this time assessment tools for measuring tobacco usage are being considered. Tobacco usage by pregnant women will be measured pre- and post-natally with an expected outcome of reduction of smoking by the cohort over time.

Three county health departments selected NPM 14 for FY 2012. See attachment
An attachment is included in this section. IVC_NPM15_Plan for the Coming Year

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	10	10	9	9	11
Annual Indicator	19.2	16.3	11.9	13.4	13.4
Numerator	13	11	8	9	9
Denominator	67811	67574	67074	67302	67302
Data Source			MT Office of Vital Statistics and census estimates	MT Office of Vital Statistics and census estimates	MT Office of Vital Statistics and census estimates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	12.5	12.5	12	12	11.5

Notes - 2010
The data reported are for 2009. 2010 data were not available at the time of grant submittal.

Notes - 2009
The numerator includes deaths to Montana residents that were reported to the Montana Office of Vital Statistics. The denominator data is from 2009 census estimates for the population of 15-19 year olds in the state (May 2010 version). As of the 2006 data, the data for this performance measure are reported as a moving average due to the small number of events.

Notes - 2008
The numerator include deaths to Montana residents that were reported to the Montana Office of Vital Statistics. The denominator data is from 2008 census estimates for the population of 15-19 year olds in the state (May 2009 version). As of the 2006 data, the data for this performance measure are reported as a moving average due to the small number of events.

a. Last Year's Accomplishments
Local Fetal, Infant, and Child Mortality Review (FICMR) teams reviewed child deaths and implemented community activities related to the prevention of youth suicide.

The FICMR Coordinator was available as a resource via phone, email, traditional mail or in person. The FICMR Coordinator shared pertinent prevention information, current journal articles and information received from national sources related to infant and child death prevention with the local coordinators via email. The FICMR Coordinator participated on a number of committees, i.e. Injury Prevention Coalition and the Emergency Medical Services for Children (EMSC), each charged with addressing preventable unintended and intended injuries.

The Family and Community Health Bureau (FCHB) collaborates as requested or as needed with the Statewide Suicide Prevention Coordinator on efforts to prevent youth suicide in Montana.

The FCHB sustained FICMR activities with several training opportunities. The FICMR coordinator training, held February 2010, included FICMR review basics, determining preventability of deaths, death certificate information and a mock case review for 13 attendees. During this face-to-face meeting, there was discussion on the current review tool, how to keep local team members involved and an open discussion on prevention activities and lessons learned. The attendees were allowed the opportunity to ask questions about the mortality review process and how to submit a FICMR review.

The FCHB Epidemiologist analyzed the 2005-06 FICMR data and assisted with writing the final report, "A Summary of Mortality Reviews Conducted in 2005-2006." The report, which highlighted evidenced-based best practices and prevention activities in Montana including youth suicide, was distributed to the local FICMR coordinators and is available online on the FCHB website http://www.dphhs.mt.gov/PHSD/family-health/ficmr/ficmr-index.shtml

Three counties selected NPM 16 as their focus and conducted activities to help reduce the rate of suicide deaths among youths aged 15 through 19.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordination with the State Suicide Prevention Program		X		
2. Best practices for suicide prevention at the local FICMR training				X
3. Data collected on suicide rates and discussed in program summary report				X

4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The FICMR Coordinator supports state and community FICMR injury prevention efforts by providing educational meetings/trainings and serves as a resource via phone, email or in-person contact. Current journal articles and information related to youth suicide prevention are sent electronically to local FICMR coordinators.

The FICMR Coordinator attends quarterly EMSC Advisory and State Injury Prevention Coalition meetings to discuss prevention strategies and analyze data findings. The State FICMR Coordinator shares prevention information with local coordinators to assist local FICMR teams in developing community level prevention activities. The FICMR Coordinator coordinates with key stakeholders in injury prevention and the University system to discuss suicide prevention policies and implementation practices.

The FICMR Coordinator continues utilizing coordinator trainings and meetings to educate coordinators on how to accurately complete the FICMR data reporting form. The FICMR Coordinator attended the Child Death Review National Conference and is a member of a regional coalition, of which youth suicide is a priority.
FICMR data collection and the National Child Death Review (CDR) database were reviewed and future FICMR reports will be evaluated using the National CDR database. FCHB plans on making the change during Federal Fiscal Year 2012.

Local FICMR Teams continue to review child deaths and implement community activities related to prevention of youth suicide.

c. Plan for the Coming Year
The Fetal, Infant and Child Mortality Review (FICMR) Program will continue to support community and state efforts in targeting suicide prevention among youths aged 15 through 19. The plan to target the rate of suicide deaths is to:
1) work collaboratively with local coordinators, especially those in counties experiencing higher rates,
2) work collaboratively with other agencies to target youth suicide, and
3) develop resources and tools to better understand why suicides occur and what prevention activities and/or policies will reduce rates in Montana.

The FICMR Coordinator will work collaboratively with local coordinators to address the rate of suicide by focusing on suicide prevention at the local FICMR coordinator training and meetings. Suicide is a leading cause of death among Montana youth. Goals are to strategize around prevention activities, access to resources (i.e training from the state suicide prevention specialist) and evaluate evidence-based models for effectiveness in future implementation. Local FICMR Teams will continue to review child deaths and implement community activities related to prevention of youth suicide. The State FICMR Team will no longer meet due to budget cuts.

The FICMR Coordinator will continue to attend quarterly EMSC Advisory Meetings and State Injury Prevention Coalition meetings to discuss prevention strategies and analyze data findings. The State FICMR Coordinator will share prevention information with local coordinators via email or trainings to assist local FICMR teams in developing community level prevention activities.

The FICMR Coordinator is a member of the Western-States Child Death Review Coalition, a group that meets via conference call once a month to strategize around a variety of topics. Suicide prevention, targeted to rural areas, is a topic for the coming year. Plans to implement the Child Death Review (CDR) Data Reporting system (1/1/2012) will improve national and local data, as well as prevention activities, related to youth suicides.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	91	91	91	91	75
Annual Indicator	81.8	86.8	73.0	64.1	64.1
Numerator	126	138	108	82	82
Denominator	154	159	148	128	128
Data Source			Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	65	65	65	66	66

Notes - 2010
The data reported are for 2009. 2010 data were not available at the time of grant submittal.

Notes - 2009
The data source for this measure is live birth records from the Montana Office of Vital Statistics. In 2009, Montana had three level III facilities (facilities for high-risk deliveries). The numerator and denominator include births that occurred in Montana, regardless of the mother's place of residence.

Notes - 2008
The data source for this measure is live birth records from the Montana Office of Vital Statistics. In 2008, Montana had three level 3 facilities (facilities for high-risk deliveries). The numerator and denominator include births that occurred in Montana, regardless of the mother's place of residence.

a. Last Year's Accomplishments
In April 2010, the Infant Child & Maternal Health Section (ICMHS) became part of the Maternal and Child Health Coordination section (MCHC) of the FCHB. The PHHV Nurse Consultant

position reports to the MCHC Section Supervisor.

The Family and Community Health Bureau (FCHB) funded 16 Public Health Home Visiting (PHHV) programs until 7/1/2010 when Northern Cheyenne declined a continuing contract. The remaining 15 PHHV programs continued to implement programs directed towards fulfilling Montana Code Annotated 50-19-311 which includes "low birth weight prevention."
Funding for the six enhanced PHHV sites ended in December 2009. Five of the six continued providing PHHV services.

The PHHV home visitors assessed and monitored the status of prenatal care during home visits and other face-to-face contacts with PHHV clients. PHHV home visitors provided clients with education on the importance of starting prenatal care during the first trimester and continuing prenatal care until birth of the baby. Pregnant women were assessed for risks that have the potential to affect pregnancy outcomes and provided ongoing education on the signs of preterm labor.

PHHV pregnant clients without health insurance coverage were assisted with the presumptive eligibility process, thus allowing early access to prenatal care and/or referral to Medicaid by PHHV home visitors.

PHHV sites began entering client data into the common electronic data system as of July 1, 2009. Data on outcomes related to adequacy of prenatal care using the Kotelchuck Index and referrals to health care resources is being collected. Of the 71 reports for women who had intake and outcome in the PHHV program during the time period 7/1/2009 through 12/31/2009, ten percent (n=7) self-reported delivering an infant weighing less than 2500 grams.*

The FCHB staff collaborated with the following: March of Dimes Montana Chapter (to focus on prematurity prevention), the Family Planning Programs in Montana (to counsel and refer clients with positive pregnancy tests to early prenatal care), and WIC providers (to refer pregnant clients to PHHV services and early prenatal care if needed).

Each of the 16 PHHV sites had quality assurance on-site visits between 2/22/2010 and 8/4/2010.
*Represents data collected by local PHHV sites and submitted to DPHHS for clients who had intake and outcome during 1 July 2009 through 31 December 2009.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provision of PHHV to high-risk pregnant women and infants	X			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The PHHV Nurse Consultant supports state and community PHHV efforts as a resource via phone, email or in-person contact. Links to training and information related to pre-term labor prevention are shared with PHHV home visitors.

FCHB continues to fund 15 PHHV programs, which uphold the Montana Initiative for the Abatement of Mortality Act (MCA 50-19-311) and provide information and referrals to pregnant women to prevent low birth weight. The PHHV home visitors assist clients to enter into early and continuous prenatal care.
Since SFY 2010, PHHV sites are visited at least once a year by a PHHV Nurse Consultant. The sites are monitored for their compliance with program requirements and the FCHB staff provides technical assistance as needed. Site visit quality assurance forms include chart review to monitor the appropriateness of referrals.

PHHV visitors distribute materials on detection of pre-term labor to pregnant women. Women are then empowered to fully participate in medical prenatal care by contacting the provider if signs of preterm labor occur.

c. Plan for the Coming Year
During the coming year, Montana will administer funding to local health departments for home visiting efforts. The state funded Public Health Home Visiting (PHHV) administration of funds from DPHHS to fourteen county and one tribal health department will continue and the Affordable Care Act (ACA) Maternal Infant Early Childhood Home Visiting (MIECHV) program will begin in one county using the Parents as Teachers (PAT) evidenced based model for home visiting.

Both of the home visiting programs will assess for and intervene to prevent low birth weight. The assessment methods are discussed below in the description for each program.

The state contracts with the fourteen county and one tribal health department will require the site visitors to assess pregnant women for the risk of delivering a low birth weight infant. The PHHV programs will be asked to do surveillance and assessment of county births with the infant weighing less than 2500 grams. The contract-proposed language is as follows:

Educate HRPW clients on the importance of carrying a pregnancy to 39 to 40 weeks and the signs and symptoms of early labor. In the event the HRPW is evidencing signs, the home visitor must facilitate access to medical evaluation.
With the implementation of an updated DPHHS web-site with an intended audience of the general public, the site can contain a listing of Montana hospitals and nurseries with various NICU levels. The usefulness of the site will be dependent upon explanation to the general public about the necessity to prevent low weight infant births.

DPHHS will continue to partner with agencies such as the March of Dimes, to alert the public of the need to avert low birth weight infant deliveries.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	85.4	85.9	84.5	73	74
Annual Indicator	82.4	82.1	71.3	73.1	73.1
Numerator	10302	10213	8982	8061	8061
Denominator	12499	12437	12595	11029	11029

Data Source			Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	75	75	75	75	75

Notes - 2010
The data reported are for 2009. 2010 data were not available at the time of grant submittal.

Notes - 2009
The data source for this measure is the Montana Office of Vital Statistics and includes births to MT residents reported to the MT Office of Vital Statistics. 10% of births had unknown timing of prenatal care initiation. The "unknowns" are not included in the denominator. A new birth record format was implemented in 2008, which changed the way the timing of prenatal care initiation was calculated. Thus, the measure for 2008 and onward may not be comparable to previous years.

Notes - 2008
2008 data for this measure should not be compared to previous years. The data source for this measure is the Montana Office of Vital Statistics and includes births to MT residents reported to the MT Office of Vital Statistics. The decrease in the timing when prenatal care relates to changes in the way the data are collected on the new birth record format implemented in 2008. Also, 6% of records reported "unknown" timing of prenatal care initiation, a large increase from the approximately 2% unknown reported in previous years.

a. Last Year's Accomplishments
Funding for the six enhanced Public Health Home Visiting (PHHV) sites ended in December 2009. Five of the six enhanced PHHV sites continued to be PHHV sites but one site ceased to provide PHHV activities. The Family and Community Health Bureau (FCHB) funded 16 PHHV programs until 7/1/2010 when Northern Cheyenne declined a continuing contract. Fifteen PHHV programs continued. Between 2/22/2010 and 8/4/2010, all sites received a nurse consultant visit.

The PHHV home visitors assessed and monitored the status of prenatal care during home visits and other face-to-face contacts with PHHV clients. PHHV home visitors provided the PHHV client with education on the importance of early and adequate prenatal care to achieve healthy pregnancy outcomes and continuing prenatal care until birth of the baby.

All PHHV pregnant clients without health insurance coverage were assisted with the presumptive eligibility process, thus allowing access to early prenatal care and/or referral to Medicaid by PHHV home visitors. While the number of women assisted with the presumptive eligibility process is not known, reports to the FCHB indicated 82% of women reported for the time period 7/1/2009

to 12/31/2009 had Medicaid at the time of discharge from the program.

PHHV sites began entering PHHV client data elements into the common electronic data system as of July 1, 2009. Data on self reports of initiation of and number of prenatal care visits were collected 1 July-31 December 2009 by all of the PHHV sites. Seventy percent (n=76) of women served by the PHHV sites during the six month time period were reported to have begun prenatal care during the 1st trimester, 18% (n=19) of women served during the six month time period were reported to have started prenatal care in the 2nd trimester, and four percent (n=4) started during the 3rd trimester. The information was unknown for five percent (n=5). Data was missing for 3 of the 109 pregnant women reports. A total of 627 prenatal medical visits were reported by 109 women during the six month reporting period with the range of number of visits per woman being 0 to 20.*

*Represents data collected by local PHHV sites and submitted to DPHHS for clients who had intake and outcome during 1 July 2009 through 31 December 2009.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provision of PHHV to high-risk pregnant women and infants	X			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Nurse consultation for PHHV sites occurs within the Maternal and Child Health Coordination Section (MCHC) of the FCHB. The PHHV Nurse Consultant position reports to the MCHC Section Supervisor. The PHHV Nurse Consultant supports state and community PHHV efforts via phone, email or in-person contacts. Current information related to the importance of early prenatal care is provided to PHHV home visitors.

The FCHB funds 15 PHHV programs which provide home visiting services to high risk pregnant women to promote healthy pregnancy outcomes. (see attached)

The PHHV home visitors assess and monitor the status of prenatal care during home visits and other face-to-face contacts with PHHV clients and promote the importance of early and adequate prenatal care to pregnant women and women of childbearing age in Montana. PHHV home visitors provide the PHHV client with education on the importance of starting prenatal care as early as possible and continuing throughout the pregnancy.

The FCHB collaborates with local public health providers, physicians, March of Dimes, Family Planning Programs, and other MCH partners on issues surrounding delivery of very low birth weight infants and to counsel and refer clients with positive pregnancy tests to health care resources.

PHHV pregnant clients without health insurance coverage are assisted by PHHV home visitors with the presumptive eligibility process for Medicaid, thus facilitating access to early prenatal care and other healthcare resources.

An attachment is included in this section. IVC_NPM18_Current Activities

c. Plan for the Coming Year
As of SFY2012, DPHHS will be contracting with Lake County Health Department to implement an evidenced-based Parents as Teachers program funded by Maternal Infant Early Childhood Home Visiting (MIECHV) ACA HRSA funding. Lake County will begin working with pregnant women as early in pregnancy as possible; early and continuous prenatal care will be one goal for all pregnant women. In their proposal for use of the ACA MIECHV funding, Lake County wrote as their objective "Increase the number of pregnant women who receive prenatal care in the first trimester."

The above objective is a restatement of the Montana MIECHV Updated State Plan in which the state-wide goal is as follows: "Identify and provide comprehensive services to improve outcomes for families who reside in at risk communities" and the objective is stated: "Increase the number of pregnant women who receive prenatal care in the first trimester."

Montana DPHHS will continue to fund, with state funds, fifteen sites for home visiting. The fifteen sites are a continuation of the Montana Initiative for Abatement of Mortality in Infant (MIAMI) project which has existed since 1989. The legislation which grounds the MIAMI project is Montana Code Annotated (MCA) 50-19-311. The MIAMI project legislation contains a description of the services to be provided and one is "…assistance to low-income women and infants in gaining access to prenatal care…" so the contracts with local health departments have and will continue to have reference to MIAMI home visitors promoting early continuous prenatal care. In the contract proposed for SFY 2012 between DPHHS and local health departments, the following language will appear as the first service in the list to be provided by the local projects:

The FCHB will ensure that each HRPW/PHHV client receives early and continuous prenatal care.

D. State Performance Measures

State Performance Measure 1: *The percent of children with cleft lip and/or palate receiving care in interdisciplinary clinics.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective					
Annual Indicator					89.7
Numerator					26
Denominator					29
Data Source					CSHCN Program-CHRIS system
Is the Data Provisional or Final?					Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	90	90	90	90	90

Notes - 2010
Data are for federal fiscal year (FFY) 2010. The data reflect the number of infants born during FFY 2010 and identified as having a cleft lip and/or palate by the Children's Special Health Services (CSHS) Section (the state CSHCN program), who were seen in a cleft/craniofacial clinic.

a. Last Year's Accomplishments

The 2010 Maternal and Child Health Needs Assessment process resulted in the creation of a new state performance measure to address Children with Special Health Care Needs. The new state performance measure will be MT State Performance Measure (SPM) 01: the percent of children with cleft lip and/or palate receiving care at interdisciplinary clinics.

State Performance Measure 01 addresses Montana's MCH Priority Area of CSHCN which falls under the Public Health and Safety Division's Strategic Plan Health Improvement Priority "Maintain programs that provide services to women (pre-pregnancy, prenatal and post-natal) and children."

All children with clefts/craniofacial conditions were invited to participate in team clinics. Families diagnosed prenatally with a cleft condition were also invited to clinics to meet team providers and have feeding and treatment questions answered. Primary care providers (PCP) were encouraged to refer clients to clinic. Children were followed from birth throughout childhood and adolescence at periodic intervals. Clinics provided families with anticipatory guidance and opportunity to network with other families.

Team care provides children and families with a "one-stop-shopping" type of care where multiple providers are available during one visit for evaluation and consultation. CSHS bills for these clinic services and underwrites the cost of the clinics for those who do not have health coverage or are inadequately insured.

During FFY 2010, 238 individuals were seen in Cleft/craniofacial clinics for a total of 248 visits. The overall show rate for FFY 2010 was 54% with ranges between clinics sites of 48% to 68%.

During FFY 2010 CSHS was approved by the American Cleft Palate Association as an approved Cleft Palate and Craniofacial Team. As part of this process CSHS completed an analysis of speech outcomes post surgical repair of children followed in cleft clinics. (See attached) The results of this study indicated that cleft clinic speech assessment documentation is not adequate to evaluate surgical results. With the limited documentation, over half of the children with palate repairs had age-appropriate to mild impairment of speech intelligibility upon entering school, which is a goal of the Montana Cleft/craniofacial Team.

An attachment is included in this section. IVD_SPM1_Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Team care was offered to all newborns with cleft/craniofacial conditions.	X			
2. CSHS completed analysis of speech outcomes post surgical repair of children followed in cleft clinics				X
3. Primary care providers encouraged to refer clients to clinic.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Team providers continue to offer Cleft/craniofacial clinic services to children with cleft and craniofacial conditions. Between clinic follow-up is being facilitated by expanded social work hours through the regional pediatric specialty clinic sites.

Ongoing analysis of clinic attendance rates is performed quarterly. The Montana team faces the same issues as other cleft teams with regard to the dropping attendance of older children. We have continued to explore this issue and are discussing options for more involvement of older children in their treatment plans and care decisions. Team members are sensitive to school schedules, sports, and other activities the children and youth are involved with, however "treatment fatigue" continues to impact final outcomes. CSHS plans to continue working with PCPs to encourage attendance. In addition, team coordinators are committed to making contact with families soon after birth a priority.

Attached is a draft of "Prevalence and Identification of Cleft Lip and Palate in Montana". This assessment is expected to be completed in the upcoming year.

See attached "Early Identification of Cleft Lip and Palate in Montana".

Twenty-nine newborns with cleft lip and or palate were invited to attend a Montana Cleft clinic during FFY 2010. Of those, 2 have not attended a clinic to date, although they have had multiple invitations. One is scheduled to attend a clinic in September; this child was just recently referred to the clinic.

An attachment is included in this section. IVD_SPM1_Current Activities

c. Plan for the Coming Year

Montana plans to continue to provide cleft/craniofacial clinics at accessible locations in the state to assure that families have access to team care. There has been some nurse coordinator turnover this past year so we are planning to have a coordinator training to assure that all team coordinators understand cleft standards of care and the sequencing of treatment. Training will also focus on feeding infants with clefts as feedback from families continues to emphasize this as a need.

We plan to implement a plan to have ongoing speech assessments provided by school and private therapists between clinic visits with a standardized assessment form. This project was identified as a current year activity, which we were unable to complete due to staffing demands.

In partnership with the Maternal and Child Health Epidemiology Unit , CSHS will complete the assessment of "Prevalence and Identification of Cleft Lip and Palate in Montana".

State Performance Measure 2: *The percent of Medicaid clients 0 through 6 years of age who have had a dental screening during the year.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective					
Annual Indicator					24.4
Numerator					10386
Denominator					42631
Data Source					Medicaid
Is the Data Provisional or Final?					Provisional
	2011	**2012**	**2013**	**2014**	**2015**

Annual Performance Objective	1	1	1	1	1

Notes - 2010
Data are from the Montana Medicaid Program (Healthy Montana Kids Plus) and include all children enrolled in Medicaid during July 1, 2009 through June 30, 2010 (State Fiscal Year 2010) who received an oral evaluation by a dentist.

a. Last Year's Accomplishments
The 2010 Maternal and Child Health (MCH) Needs Assessment process resulted in the creation of a new state performance measure to address children's oral health. The new state performance measure will be MT State Performance Measure (SPM) 02: the percent of Medicaid clients 0 through 6 years of age who have had a dental screening during the year.

State Performance Measure 02 addresses Montana's MCH Priority Area of children's oral health which falls under the Public Health and Safety Division's (PHSD) Strategic Plan Health Improvement Priority "Maintain programs that provide services to women (pre-pregnancy, prenatal and post-natal) and children."

This performance measure was not established during this time period.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. All available data was reviewed and used to direct discussions with stakeholders regarding access to dental care issues for Medicaid families				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The state Oral Health Program is working with the state Medicaid office to improve the oral health of Medicaid clients 0 through 6 years of age. In addition to monitoring Medicaid data, the state Oral Health Program added two questions to the Behavioral Risk Factor Survey (BRFSS) pertaining to oral health. These questions will allow more insight into the availability and access to dental care for a broader range of Montanans.

All available data will be reviewed and used to direct discussions with stakeholders regarding access to dental care issues for Medicaid families.

The state oral health program is also working closely with Head Start programs across the state to standardize the dental exam forms, collect more state-level data and promote establishing a dental home for all children enrolled in Head Start programs.

c. Plan for the Coming Year
The PHSD is exploring possible implementation of a fluoride varnish program for high-risk communities, in which primary medical providers and clinical staff will be trained to perform oral

assessments, provide fluoride treatments, and help find dental homes for children 0 through 6 years of age. Clients and their families will be referred by physicians to the Medicaid care coordination program for assistance with locating a dental home.

The Oral Health Education Specialist will work closely with the one county health department that selected SPM 2. See the attachment.
An attachment is included in this section. IVD_SPM2_Plan for the Coming Year

State Performance Measure 3: *The percent of Medicaid clients who have gestational diabetes and have their blood glucose measured during the time period of six weeks to six months postpartum.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective					
Annual Indicator					11.3
Numerator					22
Denominator					194
Data Source					Linked Medicaid-birth certificate data.
Is the Data Provisional or Final?					Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	12	12	12	12	12

Notes - 2010
Data are from birth certificate and Medicaid paid claims for 2008 and 2009 births.

a. Last Year's Accomplishments
The 2010 Maternal and Child Health (MCH) Needs Assessment process resulted in the creation of a new state performance measure to address maternal health. The new state performance measure will be MT State Performance Measure (SPM) 03: the number and percent of Medicaid clients who have gestational diabetes and have their blood glucose measured during the time period of six weeks to six months postpartum.

State Performance Measure 03: addresses Montana's MCH Priority Area of maternal health which falls under the Public Health and Safety Division's Strategic Plan Health Improvement Priority "Maintain programs that provide services to women (pre-pregnancy, prenatal and post-natal) and children."

This performance measure was not established during this time period.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. All available data will be reviewed and used to direct discussions within the Public Health and Safety Division (PHSD) regarding improved follow up care and health education services for Medicaid clients with gestational diabetes.				X
2.				
3.				
4.				

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
All available data will be reviewed and used to direct discussions within the Public Health and Safety Division (PHSD) regarding improved follow up care and health education services for Medicaid clients with gestational diabetes.

c. Plan for the Coming Year
The Family and Community Health Bureau (FCHB), Office of Epidemiology and Scientific and Support (OESS), Medicaid, and the Montana Cardiovascular Disease and Diabetes Prevention Program of the Chronic Disease Prevention and Health Promotion Bureau will collaborate to promote improved follow up care and health education services for Medicaid clients with gestational diabetes mellitus (GDM). This collaboration will also improve state-level data collection and reporting for Medicaid clients with gestational diabetes.

A possible intervention which the PHSD may undertake is to work with Medicaid data to track birth records for Medicaid clients with GDM. As soon as a follow up visit is filed for the client with GDM, the Medicaid office will notify the OESS as to where the client is receiving follow up care. The MDP and OESS will prepare and send a letter from the state medical officer to the provider of care for the client. This letter will notify the provider that this client recently had GD and will also provide a reminder that this client needs to have her blood glucose measured within six weeks to six months postpartum. In addition, the provider will be informed of any available lifestyle intervention programs to which clients may be referred. Program information, locations and contact information are available to providers through a printed brochure or the website: http://www.dphhs.mt.gov/PHSD/Diabetes/DiabetesPrevention.shtml.
Medicaid claims data will be used to track whether targeted women have a blood glucose evaluation within the designated timeframe.

State Performance Measure 4: *The rate of death to children 0 through 17 years of age caused by unintentional injuries.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective					
Annual Indicator				13.6	13.6
Numerator				30	30
Denominator				219828	219828
Data Source				Death certificate data	Death certificate data
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	13	13	12	12	12

Notes - 2010
The data reported are 2009 data. 2010 data were not available at the time of grant submittal.

Notes - 2009
Includes deaths to children 1 through 17 years of age with ICD10 causes V01-X59 and Y85-Y86.

a. Last Year's Accomplishments
The 2010 Maternal and Child Health Needs Assessment process resulted in the creation of a new state performance measure to address unintentional injuries. The new state performance measure will be MT State Performance Measure (SPM) 04: the rate of death to children 0 through 17 years of age caused by unintentional injuries (per 100,000).

State Performance Measure 04 addresses Montana's MCH Priority Area of unintentional injury prevention which falls under the Public Health and Safety Division's Strategic Plan Health Improvement Priority "Reduce unintentional injuries and death among Montanans from motor vehicle occupant crashes, falls, poisoning, and other preventable injury-related risk factors."

This performance measure was not established during this time period.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The FICMR Coordinator attends quarterly EMSC Advisory and State Injury Prevention Coalition meetings to discuss prevention strategies and analyze data findings related to children 0-18 years of age				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Fetal, Infant, and Child Mortality Review (FICMR) program is part of the Maternal and Child Health Coordination section (MCHC) of the Family and Community Health Bureau (FCHB). The FICMR Coordinator supports state and community FICMR injury prevention efforts by providing educational meetings/trainings and serving as a resource via phone, email or in-person contact. Information related to unintentional injuries and death due to motor vehicle crashes, falls, drowning, unsafe sleep conditions and poisoning are disseminated to the local FICMR coordinators and state partners.

The FICMR Coordinator attends quarterly EMSC Advisory and State Injury Prevention Coalition meetings to discuss prevention strategies and analyze data findings related to children 0-18 years of age. The FICMR Coordinator shares prevention information with local coordinators via email or trainings to assist local FICMR teams in developing community level prevention activities. The FICMR Coordinator attended the National Conference on Child Death review and collaborates with regional FICMR Coordinators to address best practices related to Injury Prevention.

FICMR data collection and the National Child Death Review (CDR) database were reviewed and future FICMR reports will be evaluated using the National CDR database. FCHB plans on making the change during Federal Fiscal Year 2012.

Local FICMR Teams continue to review child deaths and implement community activities related to motor vehicle death prevention.

c. Plan for the Coming Year

The Fetal, Infant and Child Mortality Review (FICMR) Program will continue to support community and state efforts in targeting unintentional injuries. The plan to target the rate of unintentional injuries is to 1) work collaboratively with local coordinators, especially those in counties experiencing higher rates, 2) work collaboratively with other agencies to address unintentional injuries, and 3) develop resources and tools to better understand why unintentional injuries occur and what prevention activities and/or policies will reduce rates among children 0 through 17 in Montana.

The FICMR Coordinator will work collaboratively with local coordinators to address the rate of deaths due to unintentional injuries by focusing on motor vehicle transport, drowning, poisoning, fires and burns, firearm safety, as well as falls at the local FICMR coordinator training and meetings. Unintentional injury deaths are the leading causes of death among Montana residents, 0-17 years of age. Goals are to implement local policies to address unintentional injuries. Local FICMR Teams will continue to review child deaths and implement community activities related to prevention of deaths attributed to unintentional injuries. The State FICMR Team will no longer meet due to budget cuts, but experts on related issues will be utilized in developing activities and creating policies.

The FICMR Coordinator will continue to attend quarterly EMSC Advisory Meetings and State Injury Prevention Coalition meetings to discuss prevention strategies and analyze data findings. The State FICMR Coordinator will share prevention information with local coordinators via email or trainings to assist local FICMR teams in developing community level prevention activities. The FICMR Coordinator is a member of the Safe States Alliance and will participate in trainings.

The FICMR Coordinator is a member of the Western-States Child Death Review Coalition, a group that meets via conference call once a month to strategize around a variety of topics. Plans to implement the Child Death Review (CDR) Data Reporting system (1/1/2012) will improve national and local data, as well as prevention activities, related to deaths of children 0 through 17 of age, caused by unintentional injuries.

The FICMR Coordinator will work closely with the three county health departments that selected SPM 4. See the attachment.

An attachment is included in this section. IVD_SPM4_Plan for the Coming Year

State Performance Measure 5: *The precent of women who smoke during pregnancy*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective					
Annual Indicator				16.0	16.0
Numerator				1949	1949
Denominator				12158	12158
Data Source				Birth certificates	Birth certificates
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	15	15	14	14	14

Notes - 2010
Data for 2010 were not available at the time of grant submission. Data will be updated when 2010 birth data are final.

Notes - 2009
Women with "unknown" reported for smoking during pregnancy (1% of resident live births) are not included in the denominator.

a. Last Year's Accomplishments
The 2010 Maternal and Child Health Needs Assessment process resulted in the creation of a new state performance measure to address maternal and infant health. The new state performance measure will be MT State Performance Measure (SPM) 05: the percent of women who smoke during pregnancy.

State Performance Measure 05 addresses Montana's MCH Priority Area of maternal and infant health which falls under the Public Health and Safety Division's Strategic Plan Health Improvement Priority "Increase the percentage of healthy Montana babies (under 1 year) by promoting: the baby-on-back sleep position and safe environments; and adequate prenatal care to include breastfeeding education, smoking cessation and substance abuse interventions for pregnant women."

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. PHHV contracts included the wording "Increase the percentage of PHHV clients who abstain from smoking and other tobacco use during pregnancy"				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Contracts in effect for state fiscal year 2011 (SFY 10) between DPHHS and 15 Public Health Home Visiting (PHHV) sites contained the following wording: 1) The Contractor agrees to provide the following services for the purposes of addressing the following outcomes as agreed upon by the PHHV Reassessment Project: Increase the percentage of PHHV clients who abstain from smoking and other tobacco use during pregnancy; 2) For each high risk pregnant woman (HRPW)/PHHV client the following required, standardized screening and/or assessment tools will be administered and the results will be entered into the client's PHHV/HDIS electronic record: The U.S. Preventive Services Task Force (USPSTF) Tobacco Cessation Counseling Guide sheet assessment tool at USPSTF least at intake for the HRPW and high-risk infant (HRI). The Tobacco Cessation Counseling Guide sheet assessment tool is located at: http://www.ahrq.gov/clinic/uspstf09/tobacco/tobaccosum2.htm

c. Plan for the Coming Year
As is consistent with the DPHHS PHSD mission statement "… improve and protect the health and safety of Montanans" the Public Health Home Visiting (PHHV) projects, through the signing

of the proposed contract for SFY 2011, will agree to " increase the percentage of H[igh] R[isk] P[regnant] W[omen] PHHV clients receiving PHHV services who quit smoking cigarettes at or before the third trimester of the pregnancy for which visits are being received and never smoke a cigarette again during this pregnancy".

From data gathered during SFY2010, the baseline for percentage change described above will be determined. PHHV sites began entering PHHV client data elements into a common electronic data system as of 1 July 2009. Data on outcomes related to pregnant women smoking, other tobacco use, cessation and referrals to cessation resources were collected 1 July-31 December 2009 by all of the PHHV sites. Thirty-four percent of PHHV women (n=109; N=488) self-reported smoking during pregnancy, Twenty-three percent of smoking PHHV women (n=37) reported smoking during the last three months of pregnancy. Thirty-five percent (n=13) reported quitting smoking during pregnancy. For quality feedback purposes, the findings for each site were compared to the consolidated data submitted from all sites and a report was given to each site so each site could evaluate whether or not efforts to reduce smoking were producing desired results. The same will be done during SFY2011 after the yearly data is submitted 15 August 2011 for the time period 1 July 2010 to 30 June 2011.

During the site visit to each of the fifteen sites by a nurse consultant, chart reviews are performed. One chart review item for pregnant women is to assess whether or not appropriate referrals were made based on the assessment data collected. In SFY 2010, each pregnant woman and primary care-giver of an infant was to be assessed using the United States Preventive Task Force (USPTF) tobacco use assessment guide. If the client is using tobacco, the home visitor is to follow the USPTF guide to assist the client in decreasing tobacco use.

A close relationship exists between the DPHHS PHHV administration and the Montana Tobacco Use Prevention Program (MTUPP) and the local PHHV home visitors often refer to MTUPP or other DPHHS sponsored tobacco use control programs located throughout the state. During record review on site visits to local PHHV sites, emphasis is given to documentation of referral of pregnant women who smoke to cessation services. If a sites data indicates a need for more diligence towards tobacco product discontinuation of clients, the nurse consultant discusses this disconnect with the local program and they brain-storm ways to increase emphasis on and discontinuation of tobacco products by women they are serving in their PHHV program. The emphasis will continue in SFY2012.

Three of the health departments that selected SPM 5 are PHHV contractors, the fourth is adjacent to one. See the attachment

An attachment is included in this section. IVD_SPM5_Plan for the Coming Year

State Performance Measure 6: *The percent of children 19-35 months of age who have received the 4th immunization in the diphtheria, tetanus, and pertussis (DTaP) series.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective					
Annual Indicator			74.4	76	79
Numerator					
Denominator					
Data Source			National Immunization	National Immunization	National Immunization

			Survey	Survey	Survey
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	80	80	80	80	80

Notes - 2010
Data are from the National Immunization Survey, July 2009-June 2010 tables. The confidence interval is +/-6.4

Notes - 2009
Data are from the 2009 National Immunization Survey. The confidence interval is +/-6.5.

Notes - 2008
Data are from the 2008 National Immunization Survey. The confidence interval is +/-6.2.

a. Last Year's Accomplishments
The 2010 Maternal and Child Health Needs Assessment process resulted in the creation of a new state performance measure to address immunizations against Diphtheria, Tetanus, and Pertussis. The new state performance measure will be MT State Performance Measure (SPM) 06: the percent of children 19-35 months of age who have received all age-appropriate immunizations against Diphtheria, Tetanus, and Pertussis.

State Performance Measure 06 addresses Montana's MCH Priority Area of Immunizations which falls under the Public Health and Safety Division's Strategic Plan Health Improvement Priority "Increase childhood immunization rates for Diphtheria,Tetanus, Pertussis and other vaccine preventable conditions."

This performance measure was not established during this time period.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The DPHHS, Immunization Section will partner with contractors to improve the immunization rate in Montana.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The FCHB developed an Immunization Activity Guide with best practices to improve immunization rates at local health departments. (see attached)

The Public Health Home Visiting (PHHV) program assesses whether infants in the program receive their two, four and six month immunizations and the PHHV provider counsels the parent on the importance of continuing scheduled immunizations for the infant.

The CYSHCN program will assess children who attend some pediatric specialty clinics for required immunizations and refer them to the appropriate resources. Interdisciplinary teams staffed by a pediatrician and/or public health nurse will review immunization status.

The WIC Program will continue to encourage parents and caregivers to obtain well childcare and refer participants to eligible programs.

The DPHHS, Immunization Section will partner with 53 contractors to improve the immunization rate in Montana.

An attachment is included in this section. IVD_SPM6_Current Activities

c. Plan for the Coming Year

The FCHB will develop a qualitative survey for local health departments to assess state support for all performance measures including NPM 07.

The Affordable Care Act Home Visiting (ACA HV) and state Public Health Home Visiting (PHHV) programs will assess whether infants in the program receive their two, four and six month immunizations. The ACA HV and state PHHV providers will counsel parents on the importance of continuing scheduled immunizations for infants.

The CYSHCN program will assess children who attend some pediatric specialty clinics for required immunizations and refer them to the appropriate resources.

The WIC Program will continue to encourage parents and caregivers to obtain well childcare and refer participants to eligible programs. The WIC certification form includes a check-off box for the health care provider to indicate if the child is up-to-date on immunizations, which then enables the WIC nutritionist to reinforce the importance of obtaining missed immunizations.

The DPHHS, Immunization Section will partner with 53 contractors to improve the immunization rate in Montana. Contractor activities will consist of:

• Maintaining immunization records in the statewide immunization registry system.
• Coordinating and providing outreach and referrals for children identified by immunization information systems who are behind in their immunizations.
• Developing and implementing a protocol for reducing missed opportunities for vaccination (eg. Review immunization records at every visit, or eliminate missed opportunities for simultaneous vaccination).
• Meeting quarterly with key internal partners to review data provided and discuss strengths and opportunities for improvement.
• Meeting quarterly with local vaccinations for children (VFC) providers to review the data reports provided by Department of Public Health and Human Services (DPHHS) and share best practices for increasing immunization rates.
• Maintaining records received from local schools for children entering kindergarten and 7th grade, review for completeness and accuracy, and follow up on children who are conditionally attending.
• Assessing immunization records of children enrolled in daycare settings for appropriate immunization status, and notify day care providers of children who are enrolled without appropriate documentation of immunization.
• Providing follow-up in the daycare settings for children not up-to-date as required for daycare attendance.
• Ensuring the perinatal hepatitis b prevention protocol is updated to include standards developed by the centers for disease control and prevention.
• Promoting delivery of vaccination services to underinsured adolescents.

Four county health departments selected SPM 6. See the attachment.

An attachment is included in this section. IVD_SPM6_Plan for the Coming Year

State Performance Measure 7: *The percent of children 19-35 months of age who have received an immunization against varicella.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective					
Annual Indicator			77.7	77.5	81.2
Numerator					
Denominator					
Data Source			National Immunization Survey	National Immunization Survey	National Immunization Survey
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	82	82	83	83	83

Notes - 2010
Data are from the July 2009-June 2010 National Immunization Survey tables. The confidence interval is +/-6.2.

Notes - 2009
Data are from the 2009 National Immunization Survey. The confidence interval is +/-6.6.

Notes - 2008
The data are from the 2008 National Immunization Survey. The confidence interval is +/- 6.0.

a. Last Year's Accomplishments
The 2010 Maternal and Child Health Needs Assessment process resulted in the creation of a new state performance measure to address immunizations against Varicella. The new state performance measure will be MT State Performance Measure (SPM) 07: the percent of children 19-35 months of age who have received all age-appropriate immunizations against Varicella.

State Performance Measure 07 addresses Montana's MCH Priority Area of Immunizations which falls under the Public Health and Safety Division's Strategic Plan Health Improvement Priority "Increase childhood immunization rates for Diphtheria, Tetanus, Pertussis and other vaccine preventable conditions."

This performance measure was not established during this time period.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The DPHHS, Immunization Section will partner with				X

contractors to improve the immunization rate in Montana.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The FCHB developed an Immunization Activity Guide with best practices to improve immunization rates at local health departments. (see attached)

The Public Health Home Visiting (PHHV) program assesses whether infants in the program receive their two, four and six month immunizations and the PHHV provider counsels the parent on the importance of continuing scheduled immunizations for the infant.

Children's Special Health Services (CSHS) will assess children who attend some pediatric specialty clinics for required immunizations and refer them to the appropriate resources. Interdisciplinary teams staffed by a pediatrician and/or public health nurse will review immunization status.

The WIC Program will continue to encourage parents and caregivers to obtain well childcare and refer participants to eligible programs.

The DPHHS, Immunization Section will partner with 53 contractors to improve the immunization rate in Montana.
An attachment is included in this section. IVD_SPM7_Current Activities

c. Plan for the Coming Year
The FCHB will develop a qualitative survey for local health departments to assess state support for all performance measures including NPM 07.

The Affordable Care Act Home Visiting (ACA HV) and state Public Health Home Visiting (PHHV) programs will assess whether infants in the program receive their two, four and six month immunizations. The ACA HV and state PHHV providers will counsel parents on the importance of continuing scheduled immunizations for infants.

The CYSHCN program will assess children who attend some pediatric specialty clinics for required immunizations and refer them to the appropriate resources.

The WIC Program will continue to encourage parents and caregivers to obtain well childcare and refer participants to eligible programs. The WIC certification form includes a check-off box for the health care provider to indicate if the child is up-to-date on immunizations, which then enables the WIC nutritionist to reinforce the importance of obtaining missed immunizations.

The DPHHS, Immunization Section will partner with 53 contractors to improve the immunization rate in Montana. Contractor activities will consist of:
• Maintaining immunization records in the statewide immunization registry system.
• Coordinating and providing outreach and referrals for children identified by immunization information systems who are behind in their immunizations.
• Developing and implementing a protocol for reducing missed opportunities for vaccination (eg.

Review immunization records at every visit, or eliminate missed opportunities for simultaneous vaccination).
• Meeting quarterly with key internal partners to review data provided and discuss strengths and opportunities for improvement.
• Meeting quarterly with local vaccinations for children (VFC) providers to review the data reports provided by Department of Public Health and Human Services (DPHHS) and share best practices for increasing immunization rates.
• Maintaining records received from local schools for children entering kindergarten and 7th grade, review for completeness and accuracy, and follow up on children who are conditionally attending.
• Assessing immunization records of children enrolled in daycare settings for appropriate immunization status, and notify day care providers of children who are enrolled without appropriate documentation of immunization.
• Providing follow-up in the daycare settings for children not up-to-date as required for daycare attendance.
• Ensuring the perinatal hepatitis b prevention protocol is updated to include standards developed by the centers for disease control and prevention.
• Promoting delivery of vaccination services to underinsured adolescents.

One county health department will focus on SPM 7 in FY 2012. See the attached map.

An attachment is included in this section. IVD_SPM7_Plan for the Coming Year

E. Health Status Indicators

Introduction

The Health Status Indicators (HSIs) provide a description and overview of the resident Montana population. They are an opportunity for the state to review and consider the current rates and trends for crucial maternal and child health (MCH) issues, such as low birth weight, very low birth weight, and deaths due to various causes. They also allow the MCH program to assess how the data have been collected and reported in the past and consider how changes in data systems and limitations in data sources may affect the quality of what is reported.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	7.3	7.2	7.4	7.1	7.1
Numerator	911	895	931	870	870
Denominator	12499	12437	12595	12280	12280
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010

The data reported are for 2009. 2010 data were not available at the time of grant submittal.

Notes - 2009

The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence.

Notes - 2008
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence.

Narrative:
Montana's low birth weight rate appears to have been gradually increasing. The low birth weight rate in 2000-2002 was 6.6 and the rate for 2006-2008 is 7.3.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	5.6	5.6	5.8	5.5	5.5
Numerator	676	671	706	657	657
Denominator	12092	12034	12203	11903	11903
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
The data reported are for 2009. 2010 data were not available at the time of grant submittal.

Notes - 2009
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence.

Notes - 2008
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence.

Narrative:
Montana's singleton low birth weight rate appears to have been gradually increasing. The singleton low birth weight rate in 2000-2002 was 5.2 and the rate for 2006-2008 is 5.7.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	1.2	1.2	1.1	1.0	1.0
Numerator	149	144	144	127	127
Denominator	12499	12437	12595	12280	12280
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
The data reported are for 2009. 2010 data were not available at the time of grant submittal.

Notes - 2009
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence.

Notes - 2008
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence.

Narrative:
Montana's very low birth weight rate appears to have been gradually increasing, although the change is fairly small. The very low birth weight rate in 2000-2002 was 1.1 and the rate for 2006-2008 is 1.2.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	0.9	0.9	0.9	0.8	0.8
Numerator	106	103	111	92	92
Denominator	12092	12034	12203	11903	11903
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
The data reported are for 2009. 2010 data were not available at the time of grant submittal.

Notes - 2009
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence.

Notes - 2008
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence.

Narrative:

Montana's singleton very low birth weight rate appears to have been gradually increasing, although the change is fairly small. The singleton very low birth weight rate in 2000-2002 was 0.8 and the rate for 2006-2008 is 0.9.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	10.7	9.6	11.8	11.1	11.1
Numerator	19	17	21	20	20
Denominator	177741	177688	178565	179582	179582
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
The data reported are for 2009. 2010 data were not available at the time of grant submittal.

Notes - 2009
The numerator is from the Montana Office of Vital Statistics and includes deaths due to unintentional injury among Montana residents aged 14 years and younger, regardless of the place of occurrence.

Notes - 2008
The numerator is from the Montana Office of Vital Statistics and includes deaths due to unintentional injury among Montana residents aged 14 years and younger, regardless of the place of occurrence. The denominator is from the census estimates (May 2009 version). As of the 2005 data, this indicator is reported as a 3-year moving average due to the small number of events.

Narrative:
Montana's death rate due to unintentional injury among children 14 and younger has remained fairly stable. Unintentional injury is a leading cause of death for Montanans of all ages. Local Fetal, Infant, and Child Mortality Review teams review deaths throughout the state to determine the preventability of the deaths and identify state, local, and community-level opportunities for prevention. Approximately 80% of the 2005-2006 unintentional injury deaths in Montana or to Montana residents were reviewed by FICMR teams. Among the 2005-2006 deaths reviewed, at least 90% of unintentional injury deaths were determined to be preventable. Factors that might have contributed to the deaths include alcohol or drug use by a caregiver, poor or inadequate supervision, and lack of use of available safety measures such as seatbelts or helmets.
In addition, as of the 2009 state legislative session, a statewide injury prevention program was established, which will increase the focus on deaths due to intentional and unintentional injuries.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	5.6	5.6	6.2	5.6	5.6
Numerator	10	10	11	10	10
Denominator	177741	177688	178508	179541	179541
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
The data reported are for 2009. 2010 data were not available at the time of grant submittal.

Notes - 2009
The numerator is from the Montana Office of Vital Statistics and includes deaths due to unintentional injury among Montana residents aged 14 years and younger, regardless of the place of occurrence.

Notes - 2008
The numerator is from the Montana Office of Vital Statistics and includes deaths due to motor vehicle incidents among Montana residents aged 14 years and younger, regardless of the place of occurrence. The denominator is from the census estimates (May 2009 version). As of the 2005 data, this indicator is reported as a 3-year moving average due to the small number of events.

Narrative:
Motor vehicle deaths are a leading cause of death for Montanans of all ages. While the death rate due to motor vehicle deaths is similar to other leading causes among young children, motor vehicles start to emerge as the primary cause of death among children 6-12. Among older teens and young adults motor vehicle deaths far outpace the other leading causes. Local Fetal, Infant, and Child Mortality Review teams review deaths throughout the state to determine the preventability of the deaths and identify state, local, and community-level opportunities for prevention. Almost 80% of the 2005-2006 motor vehicle deaths in Montana or to Montana residents were reviewed by FICMR teams. Among the 2005-2006 deaths reviewed, 95% of motor vehicle deaths were determined to be preventable. Factors that might have contributed to the deaths include alcohol or drug use, lack of seat belt and child safety seat use, inattentive and reckless driving, and driver's inexperience.

In the majority of the 2005-2006 deaths the child was in a passenger vehicle, although the reviewed deaths also included pedestrians, ATVs, bicycles, and motorcycles. As of the 2009 state legislative session, a statewide injury prevention program was established, which will increase the focus on deaths due to intentional and unintentional injuries, and motor vehicle deaths in particular. A variety of prevention activities take place at the state and local levels, including support for legislation such as a primary seatbelt law (not currently passed in Montana) and graduated drivers licensing (currently required in Montana), as well as public service announcements and improved road safety.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	43.1	43.2	43.4	38.0	38.0
Numerator	59	59	59	55	55
Denominator	136834	136424	136045	144746	144746
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
The data reported are for 2009. 2010 data were not available at the time of grant submittal.

Notes - 2009
The numerator is from the Montana Office of Vital Statistics and includes deaths due to motor vehicle incidents among Montana residents aged 15-24 years, regardless of the place of occurrence. The denominator is from the census estimates (May 2010 version). As of the 2005 data, this indicator is reported as a 3-year moving average due to the small number of events.

Notes - 2008
The numerator is from the Montana Office of Vital Statistics and includes deaths due to motor vehicle incidents among Montana residents aged 15-24 years, regardless of the place of occurrence. The denominator is from the census estimates (May 2009 version). As of the 2005 data, this indicator is reported as a 3-year moving average due to the small number of events.

Narrative:
Motor vehicle deaths are a leading cause of death for Montanans of all ages. While the death rate due to motor vehicle deaths is similar to other leading causes among young children, motor vehicles start to emerge as the primary cause of death among children 6- 12. Among older teens and young adults motor vehicle deaths far outpace the other leading causes. Local Fetal, Infant, and Child Mortality Review teams review deaths throughout the state to determine the preventability of the deaths and identify state, local, and community-level opportunities for prevention. Almost 80% of the 2005-2006 motor vehicle deaths in Montana or to Montana residents were reviewed by FICMR teams. Among the 2005-2006 deaths reviewed, 95% of motor vehicle deaths were determined to be preventable. Factors that might have contributed to the deaths include alcohol or drug use, lack of seat belt and child safety seat use, inattentive and reckless driving, and driver's inexperience. reviewed deaths also included pedestrians, ATVs, bicycles, and motorcycles. As of the 2009 state legislative session, a statewide injury prevention program was established, which will increase the focus on deaths due to intentional and unintentional injuries, and motor vehicle deaths in particular.

A variety of prevention activities take place at the state and local levels, including support for legislation such as a primary seatbelt law (not currently passed in Montana) and graduated drivers licensing (currently required in Montana), as well as public service announcements and improved road safety

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010

Annual Indicator	169.7	256.9	211.8	217.8	217.8
Numerator	301	458	381	393	393
Denominator	177413	178268	179889	180465	180465
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
The data are from 2009 and include Montana residents only. 2010 data were not available at the time of grant submittal. Data provided my the Montana Hospital Association. Hospital discharge data are limited to Montana occurrences and reporting hospitals.

Notes - 2009
The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

Notes - 2008
2008 data are from the hospital discharge data. The numerator includes non-fatal injuries to Montana residents only. The denominator is the census estimate of children 14 years and younger in 2008 (May 2009 version).

Narrative:
Prior to 2007, the data source for this indicator was the State Trauma Registry (STR), the most complete source of data on nonfatal injuries in the state at the time. However, the data from this source is considered to substantially underestimate of the actual rate of nonfatal injuries. Also, trauma registry data was not a good indicator of trends, as the data quality changed from year to year. For instance, in 2007 one of the large hospitals in the state did not report any data to the registry.

Since 2007, the data source for this indicator is hospital discharge data, a more complete source of data than the State Trauma Registry. The data reported for this indicator includes nonfatal injuries for Montana residents only.

Hospital discharge data reporting is not mandatory in Montana, does not include data from all hospitals, and does not include emergency department data. The hospital discharge data that are available do not in most cases include the ecodes required to assess the types of injuries treated. A bill introduced in the 2009 Montana legislature to make hospital discharge data reporting mandatory did not pass. However, a statewide injury prevention program was established, which will increase the focus on injuries and is expected to assist in improving the quality of hospital discharge data. A variety of injury prevention activities take place at the state and local levels, such as safety awareness education, Safe Kids/Safe Communities programs, and other activities targeted through various programs.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**

Annual Indicator	433.1	398.3	365.3	288.1	288.7
Numerator	767	710	657	520	521
Denominator	177112	178268	179844	180465	180465
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
Numerator data from Montana Department of Transportation Traffic Safety. Denominator data from July 1, 2009 census estimates, as estimates have not yet been released for 2010.

Notes - 2009
Numerator data from Montana Department of Transportation Traffic Safety. Denominator data from census estimates. Updated for 2011 submission.

Notes - 2008
Numerator data from Montana Department of Transportation Traffic Safety. Denominator data from census estimates. Updated for 2011 submission.

Narrative:
There has been a steady decline in the motor vehicle crashes among young children in the past few years. The change coincides with the implementation of graduated driver licensing. There have also been multiple public education campaigns and other activities to increase child safety seat and seat belt usage and reduce drunk driving. As of the 2009 state legislative session, a statewide injury prevention program was established, which will increase the focus on intentional and unintentional injuries, and motor vehicle incidents in particular. A variety of prevention activities take place at the state and local levels, including support for legislation such as a primary seatbelt law (not currently passed in Montana) and graduated drivers licensing (currently required in Montana), as well as public service announcements and improved road safety.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	2,273.7	2,150.2	1,909.4	1,577.9	1,444.9
Numerator	3114	2912	2592	2266	2075
Denominator	136959	135429	135746	143606	143606
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
Numberator data from Montana Department of Transportation Traffic Safety. Denominator data from July 1, 2009 census estimates, as estimates have not yet been released for 2010.

Notes - 2009
Numerator data from Montana Department of Transportation Traffic Safety. Denominator data from census estimates. Updated for 2011 submission.

Notes - 2008
Numerator data from Montana Department of Transportation Traffic Safety. Denominator data from census estimates. Updated for 2011 submission.

Narrative:
There has been a steady decline in the motor vehicle crashes among young children in the past few years. The change coincides with the implementation of graduated driver licensing. There have also been multiple public education campaigns and other activities to increase child safety seat and seat belt usage and reduce drunk driving. As of the 2009 state legislative session, a statewide injury prevention program was established, which will increase the focus on intentional and unintentional injuries, and motor vehicle incidents in particular. A variety of prevention activities take place at the state and local levels, including support for legislation such as a primary seatbelt law (not currently passed in Montana) and graduated drivers licensing (currently required in Montana), as well as public service announcements and improved road safety.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	22.1	23.5	27.7	24.6	24.6
Numerator	720	794	926	807	807
Denominator	32551	33850	33488	32789	32789
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2010
The data reported are 2009 data. Data will be updated for the September submission.

Notes - 2009
The source for the numerator is the STD Surveillance Database, STD MIS, from calendar year 2009. The denominator is from census estimates of Montana resident females 15-19 years of age in 2009 (June 2010 version). Reporting for 2009 may not be complete.

Notes - 2008
The source for the numerator is the STD Surveillance Database, STD MIS, from calendar year 2008. The denominator is from census estimates of Montana resident females 15-19 years of age in 2008 (June 2010 version). The increase in the rate for 2008 is believed to be due to improved case reporting and an increase in the number of sites that reported test results, not because of an increase in cases.

Narrative:

The gradual increase in the chlamydia rate for 15-19 year olds is believed to be due to improved case reporting and an increase in the sites that reported test results. Reporting for 2009 may not be complete.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	7.7	7.8	8.4	8.6	8.6
Numerator	1140	1158	1249	1292	1292
Denominator	147904	148467	149294	149491	149491
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2010
The data reported are 2009 data. Data will be updated for the September submission.

Notes - 2009
The source for the numerator is the STD Surveillance Database, STD MIS, from calendar year 2008. The denominator is from census estimates of Montana resident females 20-44 years of age in 2008 (June 2010 version). Reporting for 2009 may not be complete.

Notes - 2008
The source for the numerator is the STD Surveillance Database, STD MIS, from calendar year 2008. The denominator is from census estimates of Montana resident females 20-44 years of age in 2008 (June 2010 version). The increase in the rate for 2008 is believed to be due to improved case reporting and an increase in the number of sites that reported test results, not because of an increase in cases.

Narrative:
The gradual increase in the chlamydia rate for 20-44 year olds is believed to be due to improved case reporting and an increase in the sites that reported test results. Reporting for 2009 may not be complete.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	12838	10920	275	1473	170	0	0	0
Children 1	49600	41738	1162	6069	631	0	0	0

through 4								
Children 5 through 9	58491	49826	1389	6576	700	0	0	0
Children 10 through 14	59536	51950	1228	5712	646	0	0	0
Children 15 through 19	68108	59753	1119	6546	690	0	0	0
Children 20 through 24	75498	67438	906	6150	1004	0	0	0
Children 0 through 24	324071	281625	6079	32526	3841	0	0	0

Notes - 2012
Data are from the 2009 census estimates (released in May 2010). Estimates for Native Hawaiian, more than one race, and other/unknown are not available.

Data are from the 2009 census estimates (released in May 2010). Estimates for Native Hawaiian, more than one race, and other/unknown are not available.

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Data are from the 2009 census estimates (released in May 2010). Estimates for Native Hawaiian, more than one race, and other/unknown are not available.

Narrative:
The data source for this indicator is census estimates.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	12255	583	0
Children 1 through 4	46782	2818	0
Children 5 through 9	55082	3409	0
Children 10 through 14	56555	2981	0
Children 15 through 19	65273	2835	0
Children 20 through 24	72885	2613	0
Children 0 through 24	308832	15239	0

Notes - 2012
Data are from the 2009 census estimates (released in May 2010).

Data are from the 2009 census estimates (released in May 2010).

Data are from the 2009 census estimates (released in May 2010).

Data are from the 2009 census estimates (released in May 2010).

Data are from the 2009 census estimates (released in May 2010).

Data are from the 2009 census estimates (released in May 2010).

Narrative:
The data source for this indicator is census estimates.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	2	1	0	1	0	0	0	0
Women 15 through 17	359	217	3	120	0	0	12	7
Women 18 through 19	906	614	1	230	3	0	34	24
Women 20 through 34	9656	8239	38	1008	24	6	177	164
Women 35 or older	1357	1150	0	92	79	0	18	18
Women of all ages	12280	10221	42	1451	106	6	241	213

Notes - 2012
Births to Pacific Islanders are included in "Asian" due to the format of the available data.

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Births to Pacific Islanders are included in "Asian" due to the format of the available data.

Narrative:
The data source for this indicator is live birth records from the Montana Office of Vital Statistics.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**

Women < 15	2	0	0
Women 15 through 17	329	30	0
Women 18 through 19	854	52	0
Women 20 through 34	9401	310	0
Women 35 or older	1269	33	0
Women of all ages	11855	425	0

Notes - 2012

Narrative:
The data source for this indicator is live birth records from the Montana Office of Vital Statistics.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	72	50	1	16	0	0	4	1
Children 1 through 4	20	14	0	5	0	0	1	0
Children 5 through 9	13	11	0	2	0	0	0	0
Children 10 through 14	11	9	0	2	0	0	0	0
Children 15 through 19	55	37	0	16	0	0	2	0
Children 20 through 24	87	62	0	21	1	0	3	0
Children 0 through 24	258	183	1	62	1	0	10	1

Notes - 2012
Data are from 2009 death records for Montana residents. 2010 data were not available at the time of grant submission.

Due to the format of the available data, deaths to Pacific Islanders are reported under "Asian."

Narrative:
The data source for this indicator is death records from the Montana Office of Vital Statistics.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	70	2	0
Children 1 through 4	17	3	0
Children 5 through 9	13	0	0
Children 10 through 14	11	0	0
Children 15 through 19	53	2	0
Children 20 through 24	84	3	0
Children 0 through 24	248	10	0

Notes - 2012

Narrative:
The data source for this indicator is death records from the Montana Office of Vital Statistics.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	242453	205589	3373	14351	938	1078	17124	0	2010
Percent in household headed by single parent	29.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2010
Percent in TANF (Grant) families	2.8	1.6	4.2	22.6	0.8	0.5	0.0	0.0	2010
Number enrolled in Medicaid	66660	49353	773	15373	216	26	919	0	2010
Number enrolled in SCHIP	25493	17427	84	1502	107	28	2048	4297	2010
Number living in foster home care	2840	1468	80	1050	9	5	194	34	2010
Number enrolled in food stamp program	53436	41800	451	10774	148	76	187	0	2010
Number enrolled in WIC	29291	18051	161	5326	50	39	5664	0	2010
Rate (per 100,000) of juvenile crime	4727.1	4610.7	6255.6	11016.7	4797.4	0.0	0.0	0.0	2010

arrests									
Percentage of high school drop-outs (grade 9 through 12)	4.3	3.5	0.0	10.6	1.5	4.9	0.0	6.3	2010

Notes - 2012
Data are from the US Census Bureau via the Current Population Survey Table Creator (http://www.census.gov/hhes/www/cpstc/cps_table_creator.html).

Data are from the US Census Bureau via the Current Population Survey Table Creator (http://www.census.gov/hhes/www/cpstc/cps_table_creator.html). Estimates for single parent households by race for 2010 do not appear to accurately reflect the population, thus only the total for single parent households is reported.

MT TANF Demographic Data. Data are for Federal Fiscal Y ear 2010.

The data are children 0 through 19 years who received Medicaid benefits during 2010 calendar year. The data are pull by child's DOB, race and ethncity and are unduplicate count. Data source is MT Medicaid Querypath.

Data are from MT Healthy Montana Kids (CHIP) for 2010.

MT Supplemental Nutrition Assistance Program (SNAP) Data

Numerator: MT Incident-Based Reporting System. MT Board of Crime Control data from 2010. Denominator data are from 2010 census estimates.

Other and unknown race category includes Black, Native Hawaiian/Pacific Islander. Data Source MT Office of Public Instruction. Numerator is a dropout count, denominator is enrollment count reported for 2009-2010 school year.

Narrative:
The programs that provide the data reported above have very different ways of collecting and reporting the data and do not all have standard categories of race and ethnicity. Data from the programs are often updated and cleaned throughout subsequent years, and so they may not all be final. Census estimates for Montana are often based on very small sample sizes, particularly for specific races. For these reasons, the data for HSI 09A and B are considered estimates, and the summary below focuses on the total numbers reported for 2007 and 2008 instead of comparing numbers by race and ethnicity. This is a general assessment of participation in the following situations as reported in the block grant, and may not match what the programs themselves report.

From 2008 to 2009:
The overall census estimates of children 0-19 in Montana increased.
The estimates of the percent of children in single parent households decreased.
The percent of children in TANF families increased.
The number of children enrolled in Medicaid increased.
The number of children enrolled in SCHIP increased.
The number of children living in foster home care decreased.
The number of children enrolled in the food stamp program increased.
The number of children enrolled in WIC increased.
The rate of juvenile crime arrests decreased.

The percentage of high school drop-outs decreased.

Although the Current Population Survey (CPS) is the only source of data on the percent of children in a household headed by a single parent, the sample size for Montana is so small that it does not always provide valid estimates. During a discussion with the U.S Census Bureau about the CPS estimates for Montana, they recommended not using it as a data source for this measure. However, as it is the only data source available on single parent households, the data are reported for white and American Indian only, as these are two largest population groups (by race) in the state.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	231622	10832	0	2010
Percent in household headed by single parent	0.0	0.0	29.4	2010
Percent in TANF (Grant) families	2.8	3.2	0.0	2010
Number enrolled in Medicaid	63732	3071	0	2010
Number enrolled in SCHIP	24764	729	0	2010
Number living in foster home care	2374	157	115	2010
Number enrolled in food stamp program	53436	51832	1604	2010
Number enrolled in WIC	24971	1830	0	2010
Rate (per 100,000) of juvenile crime arrests	4456.8	3028.1	0.0	2010
Percentage of high school drop-outs (grade 9 through 12)	4.3	4.3	0.0	2010

Notes - 2012
Data are from the US Census Bureau via the Current Population Survey Table Creator (http://www.census.gov/hhes/www/cpstc/cps_table_creator.html).

Data are from the US Census Bureau via the Current Population Survey Table Creator (http://www.census.gov/hhes/www/cpstc/cps_table_creator.html). Estimates for single parent households by ethnicity for 2010 do not appear to accurately reflect the population, thus only the total for single parent households is reported.

MT TANF Demographic Data. Data are for Federal Fiscal Year 2010.

The data are children 0 through 19 years who received Medicaid benefits during 2010 calendar year. The data are pull by child's DOB, race and ethncity and are unduplicate count. Data source is MT Medicaid Querypath.

Data are from MT Healthy Montana Kids (CHIP) for 2010.

MT Supplemental Nutrition Assistance Program (SNAP) Data. Data are for 2010.

The source is from the MT State WIC Program. Data are for FFY 2010. Data are final.

Numerator: MT Incident-Based Reporting System. MT Board of Crime Control data from 2010. Denominator data are from 2010 census estimates.

Data Source MT Office of Public Instruction. 200-2010 school year.

Data source is the Child and Family Services Division of MT DPHHS for 2010.

Narrative:
The programs that provide the data reported above have very different ways of collecting and reporting the data and do not all have standard categories of race and ethnicity. Data from the programs are often updated and cleaned throughout subsequent years, and so they may not all be final. Census estimates for Montana are often based on very small sample sizes, particularly for specific races. For these reasons, the data for HSI 09A and B are considered estimates. For additional discussion of this indicator, see Health Status Indicator 09A

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	86773
Living in urban areas	163892
Living in rural areas	85463
Living in frontier areas	0
Total - all children 0 through 19	249355

Notes - 2012
Estimates of children living in frontier areas are not included in the chart because frontier is not a category used by the census and is measured differently than rural/urban. To avoid duplication, it was not included. However, 49 counties in Montana are considered "Frontier" using the definition provided by the National Center for Frontier Communities. The total population of youth 0-19 in those 49 frontier counties is 141,666 (55% of all 0-19 year olds in the state). Likewise, there are 114,643 youth age 0-19 (45% of the total) living in non-frontier counties in the state.

Narrative:
Estimates of children living in frontier areas are not included in the chart because frontier is not a category used by the census and is measured differently than rural/urban. To avoid duplication, it was not included. However, 49 counties in Montana are considered "Frontier" using the definition provided by the National Center for Frontier Communities. The total population of youth 0-19 in those 49 frontier counties is 141,666 (55% of all 0-19 year olds in the state). Likewise, there are 114,643 youth age 0-19 (45% of the total) living in non-frontier counties in the state. Metropolitan/ Micropolitan designation used from CEIC. Metro is a subset of Urban, therefore it is also included in the urban population. Urban population= Metro+Micro, Rural is everything else.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	971032.0
Percent Below: 50% of poverty	5.4

100% of poverty	13.5
200% of poverty	35.1

Notes - 2012

Narrative:
Data Source: The data source for this measure is the U.S. Census Bureau, Current Population Survey Table Creator.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	241409.0
Percent Below: 50% of poverty	9.6
100% of poverty	21.4
200% of poverty	45.0

Notes - 2012

Narrative:
The data source for this measure is the U.S. Census Bureau, Current Population Survey Table Creator.

F. Other Program Activities

The health of the maternal and child health population, which encompasses women of childbearing age (15-44 years of age), including pregnant women, infants, children, youth, (including those with special health care needs) and their families, is of critical importance to the state and nation. Infants and children deserve excellent health services, and the Family and Community Health Bureau (FCHB) has a major role in ensuring that those services are available and accessible through the Title V MCH Block Grant Program. The FCHB also recognizes that education is intrinsically related to public health, and that a truly healthy population is one that is prepared to assess its own needs and plan accordingly. Education and health services work hand-in-hand to improve the lives of all Montanans.

Montana's 2011 MCH Block Grant application provides a look at how the FCHB, through partnerships with public and private organizations will strive to meet the needs of the MCH population.

The Primary Care Office (PCO) contracted with a private company for conducting a Dental Provider Survey, with the results primarily used for determining health professional shortage areas. Additional PCO work includes Primary Care and Mental Health Provider surveys in FY 2011.

Montana's Native American mortality rate is higher than that of the Caucasian rate and the overall rate. The state will continue addressing the state outcome measure assessing the Native American Infant Mortality Rate.

The Director of the Department of Public Health and Human Services has created the Best Beginning Communication Strategic Planning Committee, of which the Maternal and Child Health Coordination (MCHC) and WIC Section Supervisors are key members. The Committee is charged with promoting best beginning services for parents of infants and children 0 to 5 years of age. The Best Beginning services tie in with the MCH toll-free hotline which is a partnership between the FCHB and Healthy MT Kids (formerly known as CHIP).

The Children's Special Health Services (CSHS) Section continues to address how best to solicit information from the CYSHCN parents. Family representatives on the CSHS committee provide input to the FCHB regarding family concerns and needs.

The Governor's Office provides annual Tribal Relations training on issues that impact the Tribal Nations of Montana and the state-tribal relationship. FCHB supervisors and support staff have attended previous trainings and will continue to attend future trainings.

/2012/
The Primary Care Office (PCO) contracted with a private contractor that conducted Primary Care and Mental Healthcare Provider Surveys, with the results primarily used for determining health professional shortage areas. The data is also accessible for other DPHHS programs for grant applications and determining future activities that may require a healthcare professional.

The MCHC and WIC Section Supervisors contributed to several projects undertaken by the Best Beginnings Communication Strategic Planning Committee, which met throughout 2011. A project that is anticipated to be launched in August, 2011 is the Best Beginnings Calendar, a monthly calendar highlighting training opportunities, resources, and other activities for parents of children 0 to 5.

As noted elsewhere, the CSHS Section will be conducting a comprehensive CYSHCN needs assessment by December 2011. This information will be valuable for continuing to assess their needs for access to services such as healthcare and transitioning to adulthood.
The toll free hotline remains a partnership with the Healthy Montna Kids Program.
//2012//

G. Technical Assistance

The Maternal and Child Health Coordination (MCHC) Section is requesting technical assistance in developing action guides based on best practices for the top five National Performance Measures and for the seven new State Performance Measures. The new State Performance Measures address emerging health issues in Montana and the MCHC section would like to provide MCH contractors with credible action guides to address their performance measure selection and effect positive change in their communities.

The state Fetal, Infant, and Child Mortality Review (FICMR) Coordinator and MCH Epidemiologist request technical assistance on implementing the use of the Child Death Review (CDR) Case Reporting System. Guidance would include assistance with training local FICMR review teams on the use of the CDR.

Montana's Oral Health program requests technical assistance to improve and support the coordination and reporting of dental screenings recommended by Association of State and Territorial Dental Directors. The MCHC would like to provide training and information sessions/workshops for the Oral Health Partners who conduct the dental screenings. The trainings would include information on the recommended procedures for conducting the screenings, reporting the results of the dental screenings and information on dental services

available to low-income and at risk children which can be communicated to parents.

Montana's Oral Health program requests technical assistance to support the Access to Baby Child Dentistry (AbCd) program by providing guidance, leadership, technical assistance, and/or educational materials to AbCd providers/coordinators around the state who are faced with the challenge of assisting children aged 0-3 establish a dental home and low-income mothers/pregnant women receive critical dental care.

The MCHC Section requests technical assistance to develop new communication methods in order to relay and obtain relevant feedback and communication to and from MCH partners. The MCHC Section would like to provide web based, quarterly updates regarding MCH services and also provide assistance and guidance in meeting MCH goals. MCHC would also use the new communication methods to receive quarterly report/application materials from MCH contractors.

Montana's immunization rank according to the National Immunization Survey is 50th in the nation. Montana is focused on improving its rate by providing education to the MCH BG and Vaccine For Children contractors. The FCHB, in partnership with MT's Immunization Program, is focused on improving the immunization rate. Dr. Paul A . Offit, an American pediatrician specializing in infectious diseases and an expert on vaccines, immunology, and virology would be a speaker at an immunization conference.

/2012/

The FCHB's technical assistance requests include:

The local FICMR Teams have expressed an interest in adapting the CDR Case Reporting System whereby if adapted the time previously spent on completing and submitting paper FICMR forms to the state could be spent on prevention activities. If MT were to adapt the CDR Case Reporting System, the local FICMR Teams and the State FICMR Coordinator would need to be trained on the new system.

Attendees at the 2011 Family and Community Health Bureau Conference expressed an interest in having training on home visiting, focusing on the challenges associated with working with families with multiple high risks related needs. MT will be implementing evidence-based home visiting programs with the ACA MIECHV funding opportunity and will continue to support the current Public Health Home Visiting program. Home visiting training would benefit both programs.

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